



Summary Program Description Guidebook

For the State Health Benefits Program and
the School Employees' Health Benefits Program



TABLE OF CONTENTS	Medical Plan Descriptions	Open Enrollment
Introduction 4	Aetna 14	Multiple Coverage under the SHBP/SEHBP is Prohibited 32
Health Benefits Eligibility 4	Horizon 18	Waiver of Coverage 32
Active Employee Eligibility 4	Prescription Drug Benefits 21	Change of Coverage 32
State Employees 4	Dental Plans 21	Effective Dates of Coverage 33
Local Employees 5	Employee Dental Plans 21	Transfer of Employment 33
Eligible Dependents 5	Retiree Dental Plans 21	Leaves of Absence 33
Medicare Coverage While Employed 6	Dental Plan Descriptions 22	Family and Medical Leave Act 34
Retiree Eligibility 6	Aetna DMO 23	Furlough 34
Aggregate of Pension Membership Service Credit 7	Cigna Dental Care DHMO 24	Workers' Compensation 34
Eligible Dependents of Retirees 7	Horizon Dental Choice Plan 25	Suspension 34
Enrolling in Retired Group Coverage 8	International Healthcare Services Inc./Healthplex 26	Return from Leave of Absence 34
Choosing A Medical Plan 8	Metlife Dental Insurance 27	End of Coverage 34
Available Medical Plans 8	Active And Retiree Dental Expense Plans (Aetna) 28	Medicare Parts A and B 35
Plan Coverage 8	Employee Assistance Programs 30	Medicare Part D 35
Choice of Provider 8	Tax\$ave For State Employees 30	Retiree Enrollment 35
How to Access Information that Can Help You Choose a Provider 9	Tax\$ave Open Enrollment 30	Supporting Documentation Required for Enrollment of Dependents 35
Plan Premiums, Copayments, And Other Costs . . 9	Effect Of POP Participation On SHBP Rules And Procedures 30	Multiple Coverage under the SHBP/SEHBP is Prohibited 35
Minimum Contribution for Health Coverage 9	Qualifying Events 31	Waiver of Coverage 35
Health Benefits Contribution Single Coverage . . 10	Declining POP 31	Medicare Part A and Part B 35
Health Benefits Contribution Member/Spouse/Partner or Parent/Child Coverage 10	Leave Without Pay 31	Medicare Part D 36
Health Benefits Contribution Family Coverage . . 10	Civil Unions, Domestic Partners, and Tax\$ave 31	Medicare Eligibility 36
Retiree Contributions 11	Enrolling In Health Benefits 32	How to File a Claim If You Are Eligible for Medicare 37
Copayments and Other Costs 11	Active Employee Enrollment 32	Additional Retiree Enrollment Information 37
High Deductible Health Plans (HDHP) 12	Supporting Documentation Required for Enrollment of Dependents 32	Limitations on Enrolling Dependents 37
Member Guidebooks 12		Change of Coverage 38

Effective Dates	38	Medical, Dental, and Prescription Drug Plans . .	43
End of Coverage	38	Administrative Appeals.	43
Survivor Coverage	39	Medical and Dental Plans	43
COBRA Coverage	39	HMO Plan Standards	44
Continuing Coverage When it Would Normally End	39	Emergency	44
COBRA Events	39	Minimum Coverage Requirements	44
Cost of COBRA Coverage	39	Mental Health and Alcohol/Substance Abuse . .	45
Duration of COBRA Coverage	39	New Jersey Health Care Performance Reports .	45
Employer Responsibilities under COBRA	40	New Jersey HMO Performance Report: Compare Your Choices.	45
Employee Responsibilities under COBRA	40	New Jersey Hospital Performance Report	45
Failure to Elect COBRA Coverage	40	Required Documentation For Dependent Eligibility And Enrollment	46
Termination of COBRA Coverage	40	Notice Of Privacy Practices To Enrollees	48
Special Plan Provisions	41	Protected Health Information (PHI)	48
Women's Health and Cancer Rights Act	41	Uses and Disclosures of PHI	48
Automobile-Related Injuries	41	Restricted Uses	48
Work-Related Injury or Disease	41	Member Rights	48
Mental Health Parity Act Requirements	41	Questions and Concerns	50
Health Insurance Portability And Accountability Act (HIPAA)	41	Health Benefits Contact Information	50
Certification of Coverage	41	Addresses	50
HIPAA Privacy	42	Telephone Numbers	50
Notice Of Provider Termination	42	Health Benefits Publications	50
Medical Plan Extension Of Benefits	42	General Publications	50
Audit Of Dependent Coverage	42	Health Benefit Fact Sheets	51
Health Care Fraud	42	Health Plan Member Guidebooks	51
Appendix	43		
Claim Appeal Procedures	43		
Medical Appeals	43		

INTRODUCTION

The State Health Benefits Program (SHBP) was established in 1961. It offers medical, dental, and prescription drug coverage to qualified State and local government public employees, retirees, and eligible dependents. Local employers must adopt a resolution to participate in the SHBP.

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the SHBP.

The State Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.25 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The School Employees' Health Benefits Program (SEHBP) was established in 2007. It offers medical, dental, and prescription drug coverage to qualified local education public employees, retirees, and eligible dependents. Local education employers must adopt a resolution to participate in the SEHBP.

The School Employees' Health Benefits Commission (SEHBC) is the executive organization responsible for overseeing the SEHBP.

The School Employees' Health Benefits Program Act is found in the New Jersey Statutes Annotated, Title 52, Article 14-17.46 et seq. Rules governing the operation and administration of the program are found in Title 17, Chapter 9 of the New Jersey Administrative Code.

The New Jersey Division of Pensions & Benefits (NJDPB), specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP and the SEHBP.

The purpose of this *Summary Program Description* is to provide an overview of the plans provided through the SHBP and SEHBP. The individual plans' member guidebooks provide detailed information about each plan and should be used to assist you in making informed health care decisions for you and your family. Every effort has been made to ensure the accuracy of the *Summary Program Description*; however, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. **If you believe that there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, then the law, regulations, and contracts will govern. However, if you are unsure whether a procedure is covered, contact your plan before you receive services to avoid any denial of coverage issues that could result.**

Any reference in this *Summary Program Description* to the "Programs" will mean both the SHBP and SEHBP unless otherwise indicated.

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material, please write to the Division of Pensions & Benefits, P.O. Box 295, Trenton, NJ 08625-0295, call us at (609) 292-7524, or send email to: pensions.nj@treas.nj.gov

Refer to page 51 for additional information on contacting the SHBP, SEHBP, and their related health services.

HEALTH BENEFITS ELIGIBILITY

Active Employee Eligibility

Eligibility for coverage is determined by the SHBP or SEHBP. Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the NJDPB. If you have any questions concerning eligibility provisions, you should contact the NJDPB Office of Client Services at (609) 292-7524.

Any newly-appointed or elected officer will be required to work a minimum of 35 hours per week to be con-

sidered "full-time" and eligible for coverage under the SHBP/SEHBP.

Any employee or officer of a local employer or the State who was enrolled on or before May 21, 2010, is eligible for continued coverage based on the minimum work hour requirements in place prior to May 21, 2010, provided there is no break in the employee's/officer's service or reduction in work hours.

State Employees

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires at least 35 hours per week or more if required by contract or resolution.

The following categories of employees are also eligible for coverage.

- **State Part-Time Employees** — A part-time employee of the State — or a part-time faculty member at an institution of higher education that participates in the SHBP — will be eligible for coverage under a SHBP medical plan and the Prescription Drug Plans if the employee is also enrolled in a State-administered retirement system. The employee must pay the full cost of the coverage. A part-time employee will not qualify for employer- or State-paid post-retirement health benefits, but may enroll in the SHBP Retired Group at his/her own expense provided the employee was covered by the SHBP up to the date of retirement. See the *Health Benefits Coverage for Part-Time Employees* Fact Sheet for details.

- **State Colleges and Universities** — To determine hours worked per week by adjunct faculty members, State college and university employers should credit adjunct faculty with eight hours for every day the employee comes to work. For example, if the employee teaches one course per semester, for 50 minutes, three days a week; the employee would be credited with 24 hours of work per week.
- **State Intermittent Employees** — Certain intermittent State employees who have worked 750 hours in a Fiscal Year (July 1 - June 30) will be eligible for coverage under a SHBP medical plan and the Prescription Drug Plans. Eligible intermittent employees who maintain 750 hours of work per year continue to qualify for health benefits in subsequent years. See the *Health Benefits Coverage for State Intermittent Employees* Fact Sheet for details.
- **New Jersey National Guard** — A member of the New Jersey National Guard who is called to State active duty for 30 days or more is eligible to enroll in coverage under a SHBP medical plan and the Prescription Drug Plans at the State's expense. Upon enrollment, the member may also enroll eligible dependents. The Department of Military and Veteran's Affairs is responsible for notifying eligible members and for notifying the NJDPB of members who are eligible.

Local Employees

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP or SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the

NJDPB, but it can be no less than 25 hours per week or more if required by contract or resolution, or 35 hours per week for an elected or appointed official who becomes eligible after May 21, 2010. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year (the standard school year).

- **Local Part-Time Employees** — A part-time faculty member employed by a county college that participates in the SEHBP is eligible for coverage under a SEHBP medical plan — and if provided by the employer, the Prescription Drug Plans — if the faculty member is also enrolled in a State-administered retirement system. The faculty member must pay the full cost of the coverage. A part-time faculty member will not qualify for employer- or State-paid post-retirement health care benefits, but may enroll in the SEHBP Retired Group at his or her own expense provided the faculty member was continuously covered by the SEHBP up to the date of retirement. See the *Health Benefits Coverage for Part-Time Employees* Fact Sheet for details.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or same-sex domestic partner and/or your eligible children (as defined below). An eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent. Eligible children may only be covered by one participating subscriber.

Spouse — A person to whom you are legally married. A photocopy of the marriage certificate and additional supporting documentation are required for enrollment.

Civil Union Partner — A person of the same sex with whom you have entered into a civil union. A photocopy of the *New Jersey Civil Union Certificate*, or a valid certification from another jurisdiction that recognizes same-sex civil unions, and additional supporting docu-

mentation are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or the *Civil Unions and Domestic Partnerships* Fact Sheet for details).

Domestic Partner — A person of the same sex with whom you have entered into a domestic partnership as defined under P.L. 2003, c. 246 (Chapter 246), the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or an eligible employee or retiree of a participating local public entity that adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage. A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 (or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners), and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or the *Civil Unions and Domestic Partnerships* Fact Sheet for details).

Children — In compliance with the federal Patient Protection and Affordable Care Act (PPACA), coverage is extended for children until age 26, regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment (non-custodial parents see page 48).

For a stepchild, provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

For foster children and children in a guardian-ward relationship under age 26, provide a photocopy of the child's birth certificate **and** additional supporting legal documentation that attest to the legal guardianship by the covered employee (see page 48).

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section on page 40, or "Dependent Children with Disabilities" and "Over Age Children Until Age 31" below, for continuation of coverage provisions).

Dependent Children with Disabilities — If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at (609) 292-7524 or write to the Division of Pensions & Benefits, Health Benefits Bureau, P.O. Box 299, Trenton, NJ 08625 for an *Application for Continued Enrollment for Dependents with Disabilities*. The application and proof of the child's condition must be given to the NJDPB no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the *Application for Continued Enrollment for Dependents with Disabilities*.

Coverage for children with disabilities may continue only while (1) you are covered through the SHBP or SEHBP, (2) the child continues to be disabled, (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage. See the *Health Benefits Coverage Continuation for Over Age Children with Disabilities* Fact Sheet for further information.

Over Age Children Until Age 31 — Certain children over age 26 may be eligible for coverage until age 31 under the provisions of P.L. 2005, c. 375 (Chapter 375), as amended by P.L. 2008, c. 38 (Chapter 38). This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student

at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child *does not* have any choice in the selection of benefits and is enrolled in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end if the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible, or up until the paid-through date in the case of non-payment.

See the *Health Benefits Coverage of Children until Age 31 under Chapter 375* Fact Sheet for details.

MEDICARE COVERAGE WHILE EMPLOYED

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, same-sex domestic partner, or child(ren) to be covered by Medicare while the employee remains actively at work. **However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD)**, and the 30-month coordination of benefits period has ended, you and/or your dependents **must** enroll in Medicare Part A and Part B even though you are actively at work. For more information, see "Medicare Eligibility" beginning on page 36 in the "Retiree Enrollment" section.

Retiree Eligibility

The following individuals will be offered SHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement and begin receiving a monthly retirement benefit or lifetime annuity immediately following termination of employment;
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement;
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment;
- Certain local policemen or firemen with 25 years or more of service credit in the retirement system or retiring on a Disability Retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See the *Health Benefits Retired Coverage under Chapter 330* Fact Sheet for more information;
- Surviving spouses/partners and eligible children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with *less than 25 years* of service credit from an employer that participates in the SEHBP;
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS, who retire with *25 years or more* of service credit in one or more State- or locally-administered retirement systems or who retire on a Disability Retirement, even if their employer did not participate in the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State- or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit");
- Full-time members of the TPAF or PERS who retire from a non-participating board of education, vocational/technical school, or special services commission who maintain participation in the health benefits plan of their former employer may enroll in the SEHBP upon becoming eligible for Medicare;
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire or those who are on a long-term disability and begin receiving a monthly lifetime annuity immediately following termination of employment; and
- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

Eligibility for SHBP or SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a Deferred Retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is *enrolled* in the SHBP or SEHBP immediately preceding the effective date of your retirement.

This means that if your active coverage lapses because of a leave of absence, reduction in hours, or termination of employment prior to your retirement or you defer your retirement for any length of time after leaving employment, you will lose your eligibility for Retired Group health coverage (this does not include former full-time employees enrolled in TPAF and PERS board of education or county college employees who retire with 25 or more years of service).

Note: If you continue group coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (see page 40) until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

Otherwise-qualified employees whose coverage is terminated prior to retirement but who are later approved for a Disability Retirement will be eligible for coverage under the Retired Group beginning on the employee's retirement date. If the approval of the Disability Retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, or a board of education or county college employee who has 25 years or more of service credit, is eligible for full or partial State-paid health benefits under the SHBP or SEHBP. An employee of a local government who has 25 years or more of service credit, and whose employer is enrolled in the SHBP **and** has chosen to provide post-retirement medical coverage to its retirees, is eligible for full or partial employer-paid health benefits under the SHBP.

A retiree under the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from **one or more** State- or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency requested for purchase after November 1, 2008, **cannot** be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage (see page 5), except for P.L. 2005, c. 334 (Chapter 344) domestic partners described below, the Medicare requirements discussed on page 36, and other limitations listed on page 38.

Chapter 334, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers **do not** participate in the SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement, may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Enrolling in Retired Group Coverage

In most cases, the Health Benefits Bureau is notified when you file an application for retirement with the NJDPB. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

Most eligible members enrolled in coverage as active employees will automatically be enrolled as retirees. It is not necessary to complete an application. Exceptions include those members who: have changed their retirement date; waived coverage as an active employee; have applied for a Disability Retirement; or retired from non-participating employer locations. Members in any of these categories must complete a *Retiree Health Benefit Enrollment and/or Change Form* to be enrolled. If you are waiving coverage because of other coverage, a *Cancel/Decline/Waive Retired Coverage Form* must be submitted at the time of retirement in order to be eligible for enrollment if/when you lose the other coverage. If you do not submit an application within 60 days of your retirement date, you will not be permitted to enroll at a later date, unless you are subsequently approved for a Disability Retirement.

If you do not enroll in the Retired Group at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See the *Health Benefits Coverage – Enrolling as a Retiree* Fact Sheet for more information regarding eligibility, enrollment, and other important topics.

If you believe you are eligible for Retired Group coverage and **do not** receive an offering letter by the date of your retirement, contact the NJDPB Office of Client Services at (609) 292-7524 or send an email to: pensions.nj@treas.nj.gov

Additional restrictions and/or requirements may apply when enrolling in the Retired Group. Be sure to read the “Retiree Enrollment” section that begins on page 35 of this booklet.

CHOOSING A MEDICAL PLAN

The SHBP and SEHBP offer employees and retirees of the State of New Jersey and of many county, municipal, and local board of education public employers — and their eligible dependents — access to a choice of medical plans, prescription drug coverage, and dental plans.

Choosing a medical plan is an important decision and one that requires careful consideration. The following section describes the medical plans. Descriptions of prescription drug coverage and dental plans follow the medical plan description pages.

AVAILABLE MEDICAL PLANS

The following medical plans are offered to most State employees, participating local government and local education employees, and retirees.

- **Tiered-Network Plans:** Aetna Liberty Plan and Horizon Blue Cross Blue Shield of New Jersey's OMNIA Health Plan.

Note: These Plans are only available to active SHBP members.

- **Preferred Provider Organization (PPO) Plans:** Aetna Freedom10, NJ DIRECT10, Aetna Freedom15, NJ DIRECT15, Aetna Freedom1525, NJ DIRECT1525, Aetna Freedom2030, NJ DIRECT2030, Aetna Freedom2035, and NJ DIRECT2035.

Note: Aetna Freedom10 and NJ DIRECT10 are **not** available to State Employees; Medicare-eligible retirees **cannot** enroll in Aetna Freedom1525 or Aetna Freedom2030. Aetna Freedom 2035 and NJ DIRECT2035 are not available to retirees.

- **Health Maintenance Organization (HMO) Plans:** Aetna HMO, Horizon HMO, Aetna HMO1525, Horizon HMO1525, Aetna HMO2030, Horizon HMO2030, Aetna HMO2035, and Horizon HMO2035.

Note: The Horizon HMO service area is limited to New Jersey and bordering counties of Delaware, Pennsylvania, and New York; Medicare-eligible retirees cannot enroll in Aetna HMO2030. HMO1525, HMO2030, and HMO2035 plans are not available to active SHBP members.

- **High Deductible Health Plans (HDHP):** Aetna Value HD1500, NJ DIRECT HD1500, Aetna Value HD4000, and NJ DIRECT HD4000.

Note: NJ DIRECT HD4000 and Aetna Value HD4000 are **not** available to Local Education Employees; NJ DIRECT HD1500 and Aetna Value HD1500 are not available to any retirees; Medicare-eligible retirees **cannot** enroll in any of the High Deductible Health Plans (HDHP).

PLAN COVERAGE

While many services are the same from plan to plan, others may vary from one plan to another. It is important that you review the services provided by your plan, or one you are considering joining, to determine if the services meet the needs of yourself and your dependents.

Plan descriptions are available to help you compare health plan services. The plan descriptions begin on page 13 of this booklet.

CHOICE OF PROVIDER

The **Aetna Liberty Plan and the Horizon Blue Cross Blue Shield of New Jersey OMNIA Health Plan** give members the flexibility to visit high-quality practitioners in the carrier's managed care network and no referrals

are required. There is lower member cost sharing when utilizing Tier 1 providers. Tier 1 refers to specific doctors, hospitals, and other health care professionals who offer high-quality, cost-effective care. Tiered-Network plan members also have the flexibility to see any Tier 2 provider included in the managed care network, but with slightly higher cost sharing. There is no out-of-network coverage with the Tiered Plans.

Under the **Aetna Freedom** and **NJ DIRECT** plans, members may see any physician nationwide and do not need to select a Primary Care Physician (PCP) for in-network care. Aetna Freedom and NJ DIRECT plans have **in-network** benefits which apply when you select and use participating providers. Aetna Freedom and NJ DIRECT plans also offer **out-of-network** benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are provided subject to applicable copayments. Out-of-network benefits are payable subject to a deductible and coinsurance. Members are also responsible for any amount payable over the "reasonable and customary" allowance.

Retired Group members enrolled in a Medicare Advantage (MA) PPO plan – Aetna MA PPO10, Aetna MA PPO15, Horizon MA NJ DIRECT10, Horizon MA NJ DIRECT15 – can visit any Medicare-accepting provider.

The **Aetna HMO** and **Horizon HMO** plans have participating providers from which you must select a PCP. That physician coordinates all of your care. Referrals must be obtained from your PCP in order for you to visit a specialist. An annual gynecologist visit does not require a referral. Further information can be found in each plan's summary or you may call the plan directly.

Retired Group members enrolled in the **Aetna network HMO Plans** must use providers who are in the Aetna network; however, the selection of a PCP is *not* required. Please contact your provider directly to verify that he or she is in the Aetna network.

The **HDHPs** provide both in-network and out-of-network services. Members may see any physician, licensed medical provider, or hospital facility nationwide, and *do not* need to select a PCP for in-network care. One annual deductible is combined for in-network and out-of-network medical and prescription drug products and services. The entire deductible must be met before any eligible charges are reimbursed. The annual deductible applies to all services unless otherwise indicated. No copayments apply.

How to Access Information that Can Help You Choose a Provider

To help you find a physician, or to determine that a physician you wish to use is in a certain plan, call the plan directly or check the plan's website for a listing of the participating physicians. Plan telephone numbers and website addresses are found in each plan description beginning on page 13.

When choosing a provider under an HMO plan, be sure to obtain the physician's HMO Physician Identification Number. This identification number is required when you enroll.

PLAN PREMIUMS, COPAYMENTS, AND OTHER COSTS

Minimum Contribution for Health Coverage

P.L. 2011, c. 78 (Chapter 78), established new employee contribution requirements toward health benefit coverage, effective June 28, 2011.

For **State employees** paid via the State Centralized Payroll Unit and most employees of State colleges and universities, the contribution is determined as a specified percentage of the health benefits/prescription drug premiums for a salary range, but not less than 1.5 percent of salary. The calculation of the minimum 1.5 percent of salary is based on the employee's base contrac-

tual salary. In most instances, that means the salary on which pension contributions are based. However, for employees hired after July 2007 for whom pensionable salary is limited to the salary on which Social Security contributions are based, the employee's total base salary would be used. If an employee's salary increases or decreases during the year, the amount of contribution will be adjusted accordingly.

Local government and local education employees are subject to the same contribution changes required by Chapter 78, which were effective immediately for employees whose contracts were expired and employees not covered by a union contract as of June 28, 2011, and commencing upon contract expiration for employees covered by a collective negotiations agreement. Employees under a collective negotiations agreement began at Year 1 of the phase-in when the agreement expired and continued until they reach Year 4 of the phase-in.

In the case of all employers, new employees hired on or after June 28, 2011, or hired after the expiration of a collective negotiations agreement that was in force on June 28, 2011, as applicable, contribute at the highest level (Year 4).

Note: The following charts reflect the phase-in of contribution levels for employees who will pay $\frac{1}{4}$, $\frac{1}{2}$, $\frac{3}{4}$ and the full amount of the contribution rate during the phase-in years.

To calculate your total percentage of premiums, combine both the medical plan premium percentage and, if applicable, the prescription drug plan premium percentage for the appropriate level of coverage. Online Contribution Calculators are also available on the NJDPB's website.

Health Benefits Contribution for SINGLE Coverage (Percentage of Premium)*				
Salary Range	Year 1	Year 2	Year 3	Year 4**
less than \$20,000	1.13%	2.25%	3.38%	4.50%
20,000–24,999.99	1.38	2.75	4.13	5.50
25,000–29,999.99	1.88	3.75	5.63	7.50
30,000–34,999.99	2.50	5.00	7.50	10.00
35,000–39,999.99	2.75	5.50	8.25	11.00
40,000–44,999.99	3.00	6.00	9.00	12.00
45,000–49,999.99	3.50	7.00	10.50	14.00
50,000–54,999.99	5.00	10.00	15.00	20.00
55,000–59,999.99	5.75	11.50	17.25	23.00
60,000–64,999.99	6.75	13.50	20.25	27.00
65,000–69,999.99	7.25	14.50	21.75	29.00
70,000–74,999.99	8.00	16.00	24.00	32.00
75,000–79,999.99	8.25	16.50	24.75	33.00
80,000–94,999.99	8.50	17.00	25.50	34.00
95,000 and over	8.75	17.50	26.25	35.00
*Member contribution is a minimum of 1.5 percent of base salary towards health benefits.				
**Year 4 contributions took effect on July 1, 2014, for all State employees except those whose collective negotiations agreements were in force after June 30, 2011.				

Health Benefits Contribution for MEMBER/SPOUSE/PARTNER or PARENT/CHILD Coverage (Percentage of Premium)*				
Salary Range	Year 1	Year 2	Year 3	Year 4**
less than \$25,000	0.88%	1.75%	2.63%	3.50%
25,000–29,999.99	1.13	2.25	3.38	4.50
30,000–34,999.99	1.50	3.00	4.50	6.00
35,000–39,999.99	1.75	3.50	5.25	7.00
40,000–44,999.99	2.00	4.00	6.00	8.00
45,000–49,999.99	2.50	5.00	7.50	10.00
50,000–54,999.99	3.75	7.50	11.25	15.00
55,000–59,999.99	4.25	8.50	12.75	17.00
60,000–64,999.99	5.25	10.50	15.75	21.00
65,000–69,999.99	5.75	11.50	17.25	23.00
70,000–74,999.99	6.50	13.00	19.50	26.00
75,000–79,999.99	6.75	13.50	20.25	27.00
80,000–84,999.99	7.00	14.00	21.00	28.00
85,000–99,999.99	7.50	15.00	22.50	30.00
100,000 and over	8.75	17.50	26.25	35.00
*Member contribution is a minimum of 1.5 percent of base salary towards health benefits.				
**Year 4 contributions took effect on July 1, 2014, for all State employees except those whose collective negotiations agreements were in force after June 30, 2011.				

Health Benefits Contribution for FAMILY Coverage (Percentage of Premium)*				
Salary Range	Year 1	Year 2	Year 3	Year 4**
less than \$25,000	0.75%	1.50%	2.25%	3.00%
25,000–29,999.99	1.00	2.00	3.00	4.00
30,000–34,999.99	1.25	2.50	3.75	5.00
35,000–39,999.99	1.50	3.00	4.50	6.00
40,000–44,999.99	1.75	3.50	5.25	7.00
45,000–49,999.99	2.25	4.50	6.75	9.00
50,000–54,999.99	3.00	6.00	9.00	12.00
55,000–59,999.99	3.50	7.00	10.50	14.00
60,000–64,999.99	4.25	8.50	12.75	17.00
65,000–69,999.99	4.75	9.50	14.25	19.00
70,000–74,999.99	5.50	11.00	16.50	22.00
75,000–79,999.99	5.75	11.50	17.25	23.00
80,000–84,999.99	6.00	12.00	18.00	24.00
85,000–89,999.99	6.50	13.00	19.50	26.00
90,000–94,999.99	7.00	14.00	21.00	28.00
95,000–99,999.99	7.25	14.50	21.75	29.00
100,000–109,999.99	8.00	16.00	24.00	32.00
110,000 and over	8.75	17.50	26.25	35.00
*Member contribution is a minimum of 1.5 percent of base salary towards health benefits.				
**Year 4 contributions took effect on July 1, 2014, for all State employees except those whose collective negotiations agreements were in force after June 30, 2011.				

Retiree Contributions

There were no changes to contributions for those who retired prior to the enactment of Chapter 78. For active employees who subsequently retire, the following provisions apply for health benefits contributions toward post-retirement medical coverage.

Active State employees (State Departments, State colleges and universities, etc.) with 20 or more years of service credit as of June 28, 2011, are grandfathered at the 1.5 percent of salary/retirement allowance contribution requirement, but must still attain 25 years of service credit prior to retirement to qualify for State- or employer-paid contributions toward post-retirement medical coverage.

Active local government/education employees who attained 20 or more years of service credit as of June 28, 2011, are not subject to the Chapter 78 contribution requirements and will contribute in retirement in accordance with the law applicable to them prior to Chapter 78 or any applicable local ordinance or resolution. Local employees who are eligible to retire with employer-paid medical benefits at age 62 with 15 years of service with the employer, and who met those age and service requirements on or before June 28, 2011, or on or before expiration of a collective negotiations agreement that was in force on June 28, 2011, will contribute in retirement in accordance with the terms of the collective negotiations agreement applicable to them on the date they first met the age and service requirements. Retirees must still attain 25 years of service credit, or age 62 with 15 years of service with the employer, as applicable, prior to retirement to qualify for State- or employer-paid contributions toward post-retirement medical coverage.

Employees who did not have 20 years of service by June 28, 2011, and who attain 25 years of service and retire, will be subject to a contribution toward post-retirement medical coverage based on the applicable per-

centage of premium as outlined in the previous charts and determined by the annual retirement allowance. A minimum contribution of 1.5 percent of the monthly retirement allowance is required. The ABP contribution amount is based on 50 percent of the highest salary earned in the five years prior to retirement.

Copayments and Other Costs

In-Network

Aetna Freedom and **NJ DIRECT in-network** benefits, **Aetna HMO**, **Horizon HMO**, **Aetna Liberty**, and **Horizon OMNIA** require copayments for routine services such as office visits, use of emergency rooms, etc.

- **Aetna Freedom10** and **NJ DIRECT10** copayments for in-network visits to a primary doctor or a network specialist are \$10.
- **Aetna Freedom15** and **NJ DIRECT15** copayments for in-network visits to a primary doctor or a network specialist are \$15.
- **Aetna Freedom1525**, **NJ DIRECT1525**, **Aetna HMO1525**, and **Horizon HMO1525** copayments for in-network visits to a primary doctor are \$15 and visits to a network specialist are \$25.
- **Aetna Freedom2030**, **NJ DIRECT2030**, **Aetna HMO2030**, and **Horizon HMO2030** copayments for in-network visits to a primary doctor are \$20 and visits to a network specialist are \$20 for children and \$30 for adults.
- **Aetna Freedom2035**, **NJ DIRECT2035**, **Aetna HMO2035**, and **Horizon HMO2035** copayments for in-network visits to a primary doctor are \$20 and visits to a network specialist are \$35.
- For State employees, **Aetna HMO** and **Horizon HMO** copayments for visits to a primary doctor and visits to a referred specialist are \$15.

- **Aetna Liberty** and **Horizon OMNIA** copayments for primary doctors are \$5 for Tier 1 and \$20 for Tier 2. Copayments for specialists are \$15 for Tier 1 and \$30 for Tier 2.
- For local government employees, local education employees, and all retirees, **Aetna HMO/Aetna Medicare Plan (HMO)** and **Horizon HMO** copayments for visits to a primary doctor and visits to a referred specialist are \$10.

Out-of-Network

Aetna Freedom and **NJ DIRECT out-of-network** benefits require that an annual deductible be met. Deductibles are listed in the *Aetna* or *NJ DIRECT Member Guidebooks* and the Plan Comparison charts produced by the NJDPB, available on our website at: www.nj.gov/treasury/pensions

After deductibles are met, covered services are reimbursed subject to coinsurance based on the reasonable and customary allowance for the service.

- Most **Aetna Freedom10** and **NJ DIRECT10** out-of-network services are reimbursed at 80 percent of the reasonable and customary allowance after annual deductibles are met.
- Most **Aetna Freedom15**, **NJ DIRECT15**, **Aetna Freedom1525**, **NJ DIRECT1525**, **Aetna Freedom2030**, and **NJ DIRECT2030** out-of-network services are reimbursed at 70 percent of the reasonable and customary allowance after annual deductibles are met.
- Most **Aetna Freedom2035** and **NJ Direct2035** out-of-network services are reimbursed at 60 percent of the reasonable and customary allowance after annual deductibles are met.

Under **Aetna Freedom** and **NJ DIRECT out-of-network** benefits, your out-of-pocket expenses may substantially increase because you will be charged for any portion of the fee that is above the reasonable and customary amount allowed by the plan for payment to a provider for a particular service, in addition to the coinsurance.

For example, if a physician's charge for a surgical procedure is \$500 and the reasonable and customary allowance is \$400, you are responsible for the \$100 difference **in addition** to any coinsurance and deductible amounts.

High Deductible Health Plans (HDHP)

- **Aetna Value HD4000** and **NJ DIRECT HD4000** require that an annual deductible* (\$4,000 individual/\$8,000 family) be met followed by an out-of-pocket maximum (\$1,000 individual/\$2,000 family).
- **Aetna HD1500** and **NJ DIRECT HD1500** require that an annual deductible* (\$1,500 individual/\$3,000 family) be met followed by an out-of-pocket maximum (\$1,000 individual/\$2,000 family).
- Most **HDHP in-network** services are reimbursed at 80 percent of the reasonable and customary allowance after annual deductibles are met.
- Most **HDHP out-of-network** services are reimbursed at 60 percent of the reasonable and customary allowance after annual deductibles are met.

*The entire deductible must be met before any benefits are paid.

Member Guidebooks

For additional information about deductibles, coinsurance, and other out-of-pocket costs, see the medical plan member guidebooks for each of the SHBP/SEHBP plans.

The member guidebooks are plan documents that describe the terms and conditions of coverage and the benefits available under those plans. The guidebooks are available on our website.

MEDICAL PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual medical plan and intended to provide a brief overview of the plan and the benefits offered. Every effort has been made to ensure the accuracy of the information; however, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. **If you believe that there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, then the law, regulations, and contracts will govern. However, if you are unsure whether a procedure is covered, contact your plan before you receive services to avoid any denial of coverage issues that could result.**

Certain benefits or prescription drugs may require precertification prior to receiving services or purchase. Please contact your health plan for details.

If you have questions or concerns about the information presented please write to the Health Benefits Bureau, Division of Pensions & Benefits, P.O. Box 299, Trenton, NJ 08625-0299.



NJDPB
Pensions & Benefits

Explore Your Benefits



Enjoy all the benefits of being an Aetna member such as: routine checkups; hospitalization and surgery; specialty care; diagnostic testing; vision services; emergency care; anytime, anywhere, national networks; and discount programs.

Network Access — When it comes to health care, nothing may be more important to our members than having access to quality doctors and hospitals. Members have access to a national network of participating providers, so we're with you wherever you go.

Emergency Care — If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Members who are traveling outside their service area or students who are away at school are covered for emergency and urgently needed care.

Aetna Freedom Plans

How the Plan works:

Step 1: Decide if you want to go in-network or out-of-network for your care.

You have the freedom to choose any doctor — in or out of the Aetna network. But, with so many primary care doctors and specialists in New Jersey's Aetna network, chances are your doctor is one of them. You can find out right now! Visit your custom DocFind® site to search by a specific name or by zip code.

Step 2: Visit your doctor or other health care provider.

- Show your Aetna Member ID card when you go.
- Network doctors will submit claims. If you go outside the network, you can download claim forms from your secure Aetna Navigator® website.
- Network doctors will precertify services like hospital stays and outpatient surgery on your behalf. If you go outside the network, you may have to get

those permissions yourself. Just call the toll-free number on your Aetna Member ID card to do so.

Step 3: Pay your share of the cost.

- You'll generally pay less if you stay in the Aetna network. We negotiate rates with providers in the Aetna network. But, we cannot control the amount an out-of-network provider may charge.
- Most Aetna Freedom plans have no deductible for in-network services and a modest deductible for out-of-network services.
- You pay a flat copay for most in-network services. If you go outside the network, you pay a percent of the cost.

Aetna Medicare Advantage PPO ESA Plans

How the Aetna Medicare Advantage PPO ESA plan works — The Aetna MedicareSM Plan (PPO) with Extended Service Area (ESA) is for retired members enrolled in Medicare. The Aetna Medicare PPO ESA plans are primary to Medicare and pay eligible expenses directly, replacing the need for claims to first be paid by Medicare and then by a secondary plan. These plans offer services and programs beyond Original Medicare and include special programs only available to Aetna members. And, unlike a traditional PPO, you can use in-network or out-of-network providers at the in-network cost sharing amount. This gives you added flexibility when it comes to your care.

With the Aetna Medicare PPO ESA plan, you can use providers who are in or out of the plan's nationwide network. An out-of-network provider must be eligible

to receive Medicare payment and willing to accept the PPO ESA plan. Preventive benefits beyond Original Medicare are available at no additional cost.

See page 16 for additional Aetna tools, resources, and discounts.

Aetna HMO Plans

Choose an HMO plan if you like predictable costs. These HMO plans are so simple to use. Just choose a primary care physician (PCP) to be your first point of contact when you need health care. Then, simply call your PCP whenever you need care. Your PCP will build a relationship with you and get to know your health needs. Your PCP will also refer you to a specialist whenever you need one. HMO plans have no deductible with a modest copayment for most services.

How the Aetna HMO plans work:

Step 1: Choose a primary care physician (PCP) from the Aetna network.

- Your PCP is the doctor you go to first. He or she will help you learn about your health and how to manage it.
- Choosing a doctor is a personal decision. That's why each family member has his or her own PCP.
- Change your PCP anytime. Just call Member Services at the number on your member ID card. Or, visit www.AetnaStateNJ.com and click on Contact Us.

Step 2: See your doctor for checkups, or whenever you are sick or hurt.

- Your PCP will help you decide if you need care from another doctor. If so, he or she will give you a referral to another Aetna network doctor.

Step 3: Pay your share of the cost.

- A copayment is the fixed dollar amount that you pay at the time of services. It is based on which plan you selected. There may be a different copayment if you need a specialist for other services. It's that simple! There's no paperwork involved.
- Your PCP will send in any claims for services, get approval for coverage of some services when needed and usually send referrals electronically to specialists

Aetna Medicare Advantage HMO Plans

How the Aetna Medicare Advantage HMO plan works — The Aetna MedicareSM Plan (HMO) Open Access is for retired members enrolled in Medicare and goes beyond those benefits to offer you additional benefits not covered under Original Medicare. Aetna Medicare Advantage HMO Plans are primary to Medicare and pay eligible expenses directly, replacing the need for claims to first be paid by Medicare and then by a secondary plan. Our Aetna Medicare Advantage HMO plans offer you an affordable way to help you manage your health care costs and includes coverage for Medicare Parts A and B benefits.

With the Aetna Medicare Advantage HMO Plans you typically pay a flat fee, or copayment, for most covered expenses. You are required to select a Primary Care Physician (PCP) from the plan's network. With the Aetna Medicare Advantage HMO Plans Open Access, you may access care from participating providers without a PCP referral. If you seek care from a provider who does not accept the Aetna Medicare Advantage HMO Plans, services will not be covered, except in an emergency or urgent care situation, or for out-of-area kidney dialysis.

Preventive benefits beyond Original Medicare are available at no additional cost.

See page 16 for additional Aetna tools, resources, and discounts.

Aetna Value High Deductible (HD) Plans

How the Aetna Value High Deductible (HD) Plans work — An Aetna Value HD plan allows you to get more value with a low premium in exchange for a high deductible. Need to see a doctor — enjoy the freedom to choose any health care professional — in or out of the Aetna network. You can also build a tax-advantaged Health Savings Account (HSA) to put money aside for qualified health care expenses or even save towards retirement with pretax dollars. You control your health care spending with tools that can help you find the best value for your money.

Step 1: Make contributions to your HSA.

- Your contributions are tax free and you pay no taxes on qualified expenses when you use your funds.

Step 2: Visit your doctor or other health care professional.

- You may use in-network or out-of-network doctors, hospitals and other health care professionals. Network doctors are a smart value because we've negotiated special rates for Aetna members. You can use the Aetna price and quality comparison tools to shop for the best value. Network doctors will also submit claims and get approvals for you. You never need referrals with an Aetna Value plan.

Step 3: Pay your share of the cost.

- You must first meet a deductible before the plan begins to pay benefits. You choose whether to pay out of your own pocket or use the funds in your HSA.

Health Savings Account — The Aetna Value Plans include an HSA administered through PayFlex. An HSA is a special fund that allows you to put pre-tax money aside to use for qualified health care expenses. You decide if you want to use the money now for out-of-pocket costs — like your deductible or coinsurance. Or, you can pay those costs out of pocket and save your HSA for when you really need it — even for retirement! Your contributions are divided up and conveniently taken right from your paycheck. If you don't sign up for contributions right away, you can make after-tax contributions later.

See Aetna Tools, Resources, and Discounts.

Aetna Liberty Plan

You have the liberty to choose! Select the Aetna Liberty Plan if you want a lower monthly premium and low out of pocket costs when visiting Aetna's Tier 1 providers. The Aetna Liberty plan is easy to use and allows you access to specific providers in Aetna's Tier 1 or Tier 2 networks.

To find more information on the pharmacy copayments connected to your medical plan, view the *Pharmacy Copayments* document. You may also visit the NJDPB website.

How the Plan works:

Step 1: Decide if you want to go to an Aetna Liberty Tier 1 or Tier 2 provider. You will pay less visiting a Tier 1 doctor.

- Make sure you consider the Aetna Liberty Tier 1 network. When you use these providers, you'll pay less out of pocket and save!
- Aetna's Liberty Tier 1 providers are located in New Jersey, Southeastern Pennsylvania and Metro New York. Even better, you still have access to Aetna's large nationwide network. If you visit a provider outside of New Jersey, Southeastern Pennsylvania

and Metro New York and they are in-network, your eligible services will be considered Tier 2. All providers in New Jersey, Southeastern Pennsylvania and Metro are not Tier 1, so visit **DocFind®** to confirm if your provider is in Tier 1 of the Aetna Liberty Plan.

- You have the liberty to choose any doctor in Aetna's Liberty plan networks. But, with so many primary care doctors and specialists in Aetna's Tier 1 network, chances are your doctor is one of them. You can find out right now! Visit your custom **DocFind®** site to search by a specific name or by zip code.

Step 2: Visit your doctor or other health care provider.

- Show your Aetna Member ID card when you go.
- Network doctors will submit claims. If you go outside the network, you can download claim forms from your secure **Aetna Navigator®** website.
- Network doctors will precertify services like hospital stays and outpatient surgery on your behalf. If you go outside the network, you may have to get those permissions yourself, just call the toll-free number on your Aetna Member ID card to do so.

Step 3: Pay your share of the cost.

- You'll pay less out of pocket costs visiting a Tier 1 provider. When visiting a Tier 1 provider you pay a flat copay or nothing at all!
- If you visit an Aetna Liberty Tier 2 provider, you will pay a percentage of the cost for most services. But, with so many doctors and facilities in Aetna's Liberty plan network, chances are that your doctor's may participate in the Tier 1 network already.

Aetna Tools, Resources, and Discounts

Aetna Navigator™ — A powerful web-based tool designed to help you access and navigate a wide range of health information and programs. Navigator provides a single source for online benefits and health-related information. As an enrolled Aetna member, you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week where you have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to **www.AetnaStateNJ.com** and click on Quick Links to access the Aetna Navigator site.

DocFind® — It's easy to choose a PCP, search for participating physicians, hospitals and other health care providers from our extensive network via the Internet. You can select a provider based on geographic location, medical specialty, hospital affiliation, and/or languages spoken. In addition, you can obtain maps, driving directions, and physician performance summaries. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating providers. To use DocFind, simply go to **www.AetnaStateNJ.com** Member Services is also available to assist you by calling the number on the back of your ID card.

Personal Health Record — This secure, private, online resource makes it easy for you to view, access, and manage your health information. When you access your Personal Health Record, you will see that much of your medical history is already included. That makes it easy to enter more information to create a comprehensive picture of your overall health. Use it to track your health events, print it to help you fill out medical forms, or share the information with your doctor. Once you are an Aetna member, access your Personal Health Record through Aetna Navigator™ at **www.AetnaStateNJ.com** click on Quick Links to access the Aetna Navigator site.

Aetna Health Connections — A comprehensive Disease Management program designed to help you optimize your health when any one of 35-plus conditions has been identified. If you live with a chronic condition such as asthma, diabetes, heart failure, coronary artery disease, GERD, or migraines, Aetna Health Connections gives you the tools to prevent or delay complications, increase confidence in managing your condition and improve the overall quality of your life.

Have health-related questions and need answers?

— The **Informed Health Line** provides members with a toll free line to registered nurses experienced in providing information on a variety of health topics. This service is available 24 hours a day, 7 days a week. To contact the Informed Health Line call toll free 1-800-556-1555.

ActiveHealth Portal — You and your eligible dependents will have access to our health and wellness website. The website is powerful, because it is powered by your unique health information. It also is used for those interested in participating in NJWELL Program. Noted below are just a few highlights:

- All of your health information is available in one convenient place – your medical history, conditions, allergies, claims data, medications and doctors.
- We will automatically track your incentive points on our website, where you can view progress and manage your incentives.
- You will receive suggested “health actions” that are based on your health and your goals, so you know they're realistic and right for you.
- Tools and trackers are available for things like physical activity and nutrition to help keep you motivated.

- If you're looking for other health information, you'll find tips for healthy eating, recipes, a useful symptom checker, and all the latest health news.

You will be able to access the website securely from any computer or even from your smartphone or mobile device. We strive to make it easier for you. Simply log onto **www.myactivehealth.com/NJWELL** to get started.

NJWELL — The SHBP welcomes you to join NJWELL — a program designed to help actively-employed members of the SHBP live a healthy lifestyle. When you are healthier, everyone wins. You'll feel better, you'll have more energy for your family and your job, and you'll typically require less costly health care. Here's what you need to know about NJWELL:

- Program timeframe — November 1 - October 31 annually.
- NJWELL is available to active employees in the SHBP/SEHBP who are enrolled in an Aetna plan. Eligible spouses/partners can also participate as long as they are covered by the plan. Dependent children are not eligible for points and incentives.
- Eligible participants earn points when they participate in a NJWELL activity.
- Points translate to rewards:

For this coming year, eligible participants can earn up to a \$250 in Visa pre-paid card rewards. The eligible covered spouse/partner can earn his or her own pre-paid card too!

Eligible participants who reach 400 points will receive a \$125 pre-pay card 8-10 weeks after information has been reported to ActiveHealth Management. If additional points and financial incentives are earned in the program year, all other pre-paid cards will be sent at the end of the program period.

Other Discount Programs — Aetna members are eligible for discounts on:

- **Weight Loss Programs** like Jenny®, CalorieKing™, Nutrisystem®.
- **Fitness Clubs** — over 10,000 clubs to choose from nationwide including Bally Total Fitness, Curves, Gold's Gym, and many more!
- **Exercise Equipment** like elliptical machines, treadmills and exercise videos.
- **Books** from the American Cancer Society and the **MayoClinic.com** bookstores.
- **Sonicare®** electric toothbrush, EPIC gum, mints, toothpastes, and other oral health care products.
- **Aetna VisionSM Discount Program** — You are eligible to receive discounts on eyeglasses, contact lenses, and additional vision related items through the Aetna VisionSM Discount Program. The program also includes a discount on Lasik surgery. For more details about the Aetna VisionSM Discount Program from EyeMed Vision Care and to receive a listing of Vision One stores in your area, please visit **www.aetna.com**
- **Aetna HearingSM Discount Program** — Save on hearing aids and exams with Hearing Care Solutions or with HearPO®.

Employees and Non-Medicare Eligible Retirees

can contact Member Services
at 1-877-StateNJ (1-877-782-8365)

Medicare-Eligible Retirees

can contact Aetna Medicare
at 1-866-234-3129

Customer Service Representatives
are available to answer your questions
Monday through Friday
from 8:00 a.m. – 6:00 p.m. Eastern Time

Your complete guide to Aetna benefits is available at our customized SHBP/SEHBP website
at **www.AetnaStateNJ.com**

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company. Employer-funded plans are administered by Aetna Life Insurance Company or Aetna Health Administrators.



HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY... WE'VE GOT YOU COVERED

At Horizon Blue Cross Blue Shield of New Jersey, we're committed to New Jersey and its communities because we live and work here, too. For more than 50 years, we have partnered with the State of New Jersey to provide health insurance coverage for State employees, local and county governments, and many local school districts. We are proud of our long tradition of providing SHBP and SEHBP members with low-cost access to high-quality care throughout the state and across the nation. Our members receive a high level of quality service, access and patient safety, according to the National Committee for Quality Assurance (NCQA).

Choice of Plans

Members can rely on us for dependable coverage, health and wellness programs, and other resources. The health plans listed below represent the wide range of health plans available to the SHBP and SEHBP. Check with your employer for the options that are available to you.

OMNIA Health Plans	Horizon HMO
NJ DIRECT10	Horizon HMO1525
NJ DIRECT15	Horizon HMO2030
NJ DIRECT1525	Horizon HMO2035
NJ DIRECT2030	Horizon Medicare
NJ DIRECT2035	Advantage NJ DIRECT
NJ DIRECT HD1500	(PPO): available to
NJ DIRECT HD4000	SHBP only

Members can use our Doctor & Hospital Finder to find doctors, hospitals and other health care professionals who participate in our health plans.

OMNIA Health Plans

OMNIA Health Plans give members the flexibility to visit any New Jersey doctor or health care professional in the Horizon Managed Care Network, and any hospital in our Horizon Hospital Network, including participating BlueCard® PPO doctors, hospitals and other health care professionals (at the Tier 2 level of coverage). Members will save the most when they get care from OMNIA Tier 1-designated doctors, hospitals and other health care professionals — including lower deductibles, lower copayments and lower out-of-pocket costs. Members are not required to have a Primary Care Physician (PCP) and referrals are not needed for specialized care.

For more information, visit HorizonBlue.com/shbp

NJ DIRECT

NJ DIRECT plans allow members to see any doctor, nationwide, without selecting a PCP. When you use doctors and other health care professionals and facilities in our networks, you will usually pay a copayment. NJ DIRECT also offers out-of-network benefits that allow you to use any licensed doctor, health care professional or facility in the United States, but you will have to pay more for the care you receive.

For more information, visit HorizonBlue.com/shbp

NJ DIRECT High-Deductible Health Plan (HDHP) options combine a high-deductible NJ DIRECT health



plan with a Health Savings Account (HSA). Generally, HDHPs offer more value for your money through the combination of a lower premium, the tax advantages of your HSA, and tools to help control your health care spending. Any money earned through interest on your HSA balance and investments made with HSA funds is not taxed. Members own and control their HSA even when they change employers. Funds roll over from one year to the next and can be used to pay for eligible medical expenses not covered by NJ DIRECT HDHP, or to save for future medical expenses.

Members are responsible for eligible in- and out-of-network medical expenses, including prescription drugs, up to the deductible. After meeting the deductible, members are required to pay a percentage of the allowance, as well as the difference between the allowance and an out-of-network provider's charges, if applicable.

When out-of-pocket costs reach the annual out-of-pocket maximum, eligible services will be covered at 100 percent of the allowance, subject to plan provisions. For out-of-network services, the member is also responsible for any amount above the reasonable and customary allowance. Expenses for ineligible services, charges in excess of the reasonable and customary allowance, and services not authorized and determined to be ineligible do not count toward the out-of-pocket maximum.

More information on HDHPs and the financial advantages of an HSA is available at HorizonBlue.com/shbp and mybenefitwallet.com

Horizon HMO

Horizon HMO plans provide members with access to safe and effective care from doctors and other health care professionals who participate in the Horizon Managed Care Network. Members select a PCP who provides medical care and refers members to specialty care when necessary. Care received from an out-of-network physician or facility will not be covered unless it is considered a medical emergency.

For more information, visit HorizonBlue.com/shbp

Horizon Medicare Advantage NJ DIRECT (PPO)

Horizon Medicare Advantage NJ DIRECT (PPO) plans let members get care from any doctor, hospital or other health care professional who is eligible to accept Medicare payments, and agrees to provide health care services to Horizon Medicare Advantage NJ DIRECT (PPO) members. Members don't have to select a PCP or get referrals for care, and can likely continue to get care from the same doctors, hospitals and other health care professionals they use and trust today. By using providers who are in Horizon BCBSNJ's network, members will get additional care coordination services and support for health conditions, such as diabetes and congestive heart failure.

The Horizon Medicare Advantage NJ DIRECT (PPO) plans are single-coverage plans. For that reason, when Medicare-eligible SHBP retirees move to the Horizon Medicare Advantage NJ DIRECT (PPO) plan that corresponds to their current coverage, any dependents who are not Medicare-eligible will remain active in the current coverage.

Certain services require precertification. To learn more, please refer to the Medicare Advantage Evidence of Coverage (EOC) documents. A printed copy of your EOC is available upon request by calling the number on the back of the member identification (ID) card.

All plans offered to SHBP and SEHBP members include tools and resources to:

- Help you access claim information.
- Learn about coverage.
- Get your member ID card.
- View or update your account.
- Help you get care.
- Help you be well.

Get Care

24/7 Nurse Line — If members have a health question, any time of day or night, they can access our toll-free health information phone line at 1-888-901-7477 or our online live Nurse Chat service, available after signing in to Member Online Services at HorizonBlue.com/nurseline. A registered nurse will provide the information needed to make informed health care decisions.

Case Management and Member Advocacy Program

— If you or a dependent is facing a complex medical situation, we can help you by coordinating care, and providing better understanding of policies and procedures.

Chronic Care Program — This program helps members better manage their health, and provides support for managing the day-to-day challenges of living with a chronic condition, such as asthma, diabetes, Coronary Artery Disease (CAD), Chronic Kidney Disease (CKD), heart failure and Chronic Obstructive Pulmonary Disorder (COPD).

Horizon Behavioral Health and Substance Abuse

Care — We offer an extensive network of health care professionals providing a full range of counseling services and care when you or a covered dependent need care.

Laboratory Services — Horizon BCBSNJ partners with Laboratory Corp of America (LabCorp). You can find a center or schedule an appointment online at LabCorp.com. Visit patient.labcorp.com to view, download and print lab results anytime, anywhere. LabCorp connects with Microsoft HealthVault for secure, online storage of member health information.

Pharmacy Vaccine Program — Immunizations are an important step in preventing illnesses and staying healthy, and are covered under OMNIA Health Plans, NJ DIRECT and Horizon HMO when administered by your in-network doctor or a participating pharmacy in our New Jersey network.

Prescription Drug Coverage — Prescription drug coverage is available to all OMNIA Health Plan, NJ DIRECT, Horizon HMO, and Horizon Medicare Advantage NJ DIRECT (PPO) members. Please refer to the prescription drug section of this Summary Program Description for additional details.

Retail Health Clinics — Walk-in health care centers, such as MinuteClinic™ at select CVS pharmacy locations and Healthcare Clinics at select Walgreens locations throughout New Jersey, offer board-certified nurse practitioners, supervised by licensed doctors. These nurse practitioners can diagnose, treat and prescribe medication for common ailments when your doctor's office isn't open. For a list of retail health clinics, visit HorizonBlue.com/doctorfinder

Well Care and Preventive Care — Members are covered for eligible preventive care services, such as annual physical and gynecological exams, well baby/child medical care, immunizations and annual vision exams, as long as an in-network doctor provides the services. We encourage members to visit their doctor for regular checkups since illnesses are more treatable when found early.

Learn About Coverage

Horizon Connect — Our one-stop retail center, located at 1680 Nixon Drive, Moorestown, NJ, offers members personalized support. For more information, visit Connect.HorizonBlue.com

Treatment Cost Estimator — Get the big picture on the costs and services associated with an entire treatment plan, such as tests, procedures, therapy and prescriptions, from evaluation to surgery to follow-up visits. This information, which is based on a member's individual health care plan, can help members plan and understand what to expect both medically and financially. Choose a service, such as an MRI or X-ray, and a provider, and get an out-of-pocket estimate based on the plan. Service-level information on its own, or as part of a treatment or condition, will be displayed. Simply sign in to HorizonBlue.com/shbp and select Get Care.

Be Well

Blue365® — Members can save money through this national program that offers exclusive access to information and discounts on items including fitness center memberships, weight loss programs, vision and hearing programs, and supplemental health products and services. To use the discounts, sign in at Blue365deals.com/HorizonBCBS

Health Messages — We provide members with the health tips, reminders and news members need to make the most of their plan's benefits and services. Look for our online publications to keep up to date on the latest wellness information.

Health & Wellness Resources — SHBP and SEHBP members enrolled in any Horizon BCBSNJ plan have access to programs and resources designed to support healthy living.

Maternity Program — Our PRECIOUS ADDITIONS® program supports SHBP and SEHBP members who select an in-network Ob/Gyn for prenatal care. Participants receive reminders about proper prenatal and postpartum care and childhood immunizations, in addition to partial reimbursement on prenatal care classes. Through Text4baby, an expectant mother can receive educational information to her mobile phone until her child's first birthday. To sign up, simply text the word BABY (or BEBE for Spanish) to the number 511411 or register online at text4baby.org

My Health Manager — Powered by WebMD®, this is a personalized, online, interactive health resource that includes the following key features:

- Health Assessment tool
- Medication center
- Symptom checker
- Hospital quality comparison tool
- Conditions centers
- Personal health record
- Lifestyle improvement programs/online health coaching
- Personalized health comparison tool

NJWELL — This wellness program encourages actively-enrolled members and their covered spouses/partners to participate in activities geared toward taking ownership of their health and earning monetary rewards. For more information visit HorizonBlue.com/njwell

We're here for you

Horizon BCBSNJ was recognized as the most recommended health insurer in New Jersey in 2016, according to Insure.com, an industry website that offers consumer-focused insurance information and services.

Remember, members can reach Member Services via Chat or My Messages after signing in to Member Online Services at HorizonBlue.com/shbp or by calling **1-800-414-SHBP (1-800-414 7427)**.

See plan documents for a complete description, including limitations, exclusions and waiting periods.

NJ DIRECT and OMNIA are administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and Horizon HMO is administered by Horizon Healthcare of New Jersey, Inc. (HHNJ). Both Horizon BCBSNJ and HHNJ are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols, Blue 365® and BlueCard® are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols and OMNIASM are registered and service marks of Horizon Blue Cross Blue Shield of New Jersey.

MinuteClinic™ is a trademark of CVS Health.

PRESCRIPTION DRUG BENEFITS

The SHBP and SEHBC require that all covered employees and retirees have access to prescription drug coverage.

The Commissions reserve the right to establish dispensing limits on any medication based on Food and Drug Administration (FDA) recommendations and medical appropriateness. Prior Authorization, Drug Utilization Review, Dose Optimization, Step Therapy, Preferred Drug Step Therapy (PDST), and the Specialty Pharmacy Program are employed to ensure that the medications that are reimbursed under the plan are the most clinically appropriate and cost effective. Volume restrictions also apply to certain drugs such as sexual dysfunction drugs (Viagra, etc.). Certain drugs that require administration in a physician's office may be covered through your medical plan. See the *Prescription Drug Plans Member Guidebook* for more information.

DENTAL PLANS

Dental coverage is available through the Employee Dental Plans and the Retiree Dental Plans.

Employee Dental Plans

The **Employee Dental Plans** are offered to active State employees and their eligible dependents as a separate dental benefit. Local employers may also elect to provide the Employee Dental Plans to their employees as a separate dental benefit.

The offered enrollment is in one of two basic types of dental plan: one of several **Dental Plan Organizations (DPOs)** or the **Dental Expense Plan**.

- The **DPOs**, sometimes called Dental Maintenance Organizations (DMOs) or Dental Health Maintenance Organizations (DHMOs), are companies that contract with a network of providers for dental services. You must use providers who partici-

pate with the DPO you select to receive coverage. When using a DPO you pay a copayment for the services provided. Most preventive services have no copayment; restorative and other services have copayments that vary with the type of service. Be sure to confirm that a dentist or dental facility is taking new patients and participates with the DPO before you enroll.

- The **Dental Expense Plan** is a PPO plan that allows you to obtain services from any licensed dentist. After you satisfy an annual deductible (the deductible only applies to non-preventive services), you are reimbursed a percentage of the reasonable and customary charges for covered services. The plan is administered under a contract with the Aetna Life Insurance Company. By using Aetna's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

For more information about the Employee Dental Plans, see the dental plan description pages in this guidebook or the *Dental Plans – Active Employees Fact Sheet*. Information about reimbursement levels and copayment amounts is in the *Employee Dental Plans Member Guidebook*, available on the the NJDPB website.

RETIREE DENTAL PLANS

The **Retiree Dental Plans** are offered to retirees eligible to enroll in a SHBP/SEHBP Retired Group Medical plan. The offered enrollment is one of two basic types of dental plans:

- The **Retiree DPOs** are companies that contract with a network of providers for dental services. You must use providers who participate with the DPO you select to receive coverage. When using a DPO you pay a copayment for the services provided. Most preventive services have no copayment;

restorative and other services have copayments that vary with the type of service. Be sure to confirm that a dentist or dental facility is taking new patients and participates with the DPO before you enroll.

- The **Retiree Dental Expense Plan**, administered by **Aetna Dental**, is a PPO plan with in-network and out-of-network benefits that reimburse you for a portion of the expenses you and your enrolled eligible dependents incur for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. In addition, by using Aetna's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

All State and most other retirees who enroll in the Retiree Dental Plans are responsible for paying the full premium cost for coverage.

For more information about the Retiree Dental Plans, see the dental plan description pages in this booklet, the *Retiree Dental Plans Member Guidebook*, or the *Dental Plans - Retirees Fact Sheet* on our website.

DENTAL PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual dental plan and intended to provide a brief overview of the plan and the benefits offered. Every effort has been made to ensure the accuracy of the information; however, State law and the New Jersey Administrative Code govern the Employee/Retiree Dental Plans. **If you believe that there are any discrepancies between the information presented in this booklet and/or plan documents and the law, regulations, or contracts, then the law, regulations, and contracts will govern. However, if you are unsure whether a procedure is covered, contact your plan before you receive services.**

Certain benefits may require precertification prior to receiving services. Please contact your dental plan for details.

If you have questions or concerns about the information presented please write to the Health Benefits Bureau, Division of Pensions & Benefits, P.O. Box 299, Trenton, NJ 08625-0299.



NJDPB
Pensions & Benefits

Explore Your Benefits



Aetna's Dental Maintenance Organization (DMO) is a claims administrator of the SHBP Active and Retiree Dental Provider Organization (DPO).

Aetna's DMO networks are available to employees in selected states nationwide. There are no claim forms to fill out and no deductibles to pay. Each covered family member must select a participating Primary Care Dentist to coordinate all dental care.

The Retiree Dental Maintenance Organization (DMO) is a tiered benefit plan that is only available to retirees. However, both the Active and Retiree plans offer national access to dentists and quality coverage.

Dental Benefits Made Simple and Affordable!

Follow these simple steps to maximize your Aetna DMO Plan!

- Select a Primary Care Dentist in your area to visit on a regular basis and refer you to specialists within the Aetna DMO network when necessary.
- Obtain the appropriate preventive care per the benefits schedule at no charge to you (cleanings, bitewing and full-mouth X-rays, and more).
- Pay a fixed dollar amount for Basic (fillings and basic restorative work) and Major Services (bridges, crowns, dentures and more), with no deductibles or annual maximums!
- It is affordable – lower monthly premium compared to the Dental Expense Plan.

For a complete copayment schedule and services that this plan does and does not cover please refer to your *Employee Dental Plans Member Guidebook*, or the *Retiree Dental Plans Member Guidebook*.

Dental Health Information at Your Fingertips

Visit the Simple Steps to Better Dental Health website to find articles, illustrations, interactive tools, information on dental conditions, treatments, and more. To explore Simple Steps to Better Dental Health go to www.simplestepsdental.com

We offer fast, accurate customer service. Our dedicated dental service centers are staffed with dental experts who are determined to solve problems the first time, leading to fast and accurate problem resolution and claim processing.

Our technology makes it easy to get service and information when and how you want it.

- Email with 24-hour response time.
- 24-hour phone access

Our dedicated member website at www.AetnaStateNJ.com allows you to:

- Choose a plan that fits your needs
- Learn about the plan benefits
- Register for Aetna Navigator
- Search for a provider in Aetna's DocFind®
- Contact Member Services with questions

Aetna Navigator™ — A powerful web-based tool designed to help you access and navigate a wide range of oral health information and programs. Navigator provides a single source for online benefits and dental-related information. As an enrolled Aetna member you can register for a secure, personalized view of your

Aetna benefits 24 hours a day, 7 days a week where you have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to www.AetnaStateNJ.com and find Aetna Navigator under Quick Links.

DocFind® — It's easy to choose a Primary Care Dentist and search for participating specialty dentists from our extensive network via the Internet. You can select a dentist based on geographic location, dental specialty, hospital affiliation, and/or languages spoken. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating dental providers. To use DocFind, simply go to www.AetnaStateNJ.com

Member Services is also available to assist you by calling the number on the back of your ID card.

Did You Know? The signs of a health problem may show up first in your mouth, and a dentist can spot these signs. As mouth infections may affect other parts of your body, this means that good oral health has never been more important.

Aetna Membership Brings You Even More

When you enroll in an Aetna dental plan, you also get the Aetna Extras. You pay nothing to join and you'll have access to savings that can help you and your family. Save by using eight different discount programs that range from fitness and weight management to hearing and vision. Visit **Aetna Navigator** or call the number on your Aetna ID card for more information on how to access these great value-added services!



Cigna Dental Care® DHMO*

Referred to as Cigna DPO for New Jersey public employees
A dental plan that makes it easier for you to take care of your oral health

Your plan offers coverage for a wide range of services at a cost savings. Your coverage includes:

- **Preventive care** (cleanings, x-rays, and more)
- **Basic care** (fillings, basic restorative work)
- **Major services** (bridges, crowns, root canals and more)
- **Orthodontic coverage** for children and adults **

**How Your Plan Works -
it's easy to use when you follow
these simple steps**

Step 1 — Select a Network General Dentist

- You must select a dentist who participates in the DHMO network for your benefits to apply. The network general dentist you choose will manage your overall dental care.
- Covered family members can choose their own network general dentists – near home, work, or school.
- You may change your dental office for any reason. The change will become effective the first of the following month.
- Finding a DHMO network dentist is easy. There are several ways:
 - Online – Register on myCigna.com or visit the online Provider Directory on www.cigna.com
 - By phone – Call 1-800-CIGNA24 (1-800-244-6224) to use our automated Dental Office Locator or speak to a Customer Service rep-

representative. Or our service representative can send you a customized network directory listing via e-mail.

Step 2 — After You Enroll

- You will receive an ID Card, a Patient Charge Schedule (PCS) and other plan materials.
- You can make an appointment with your network general dentist for all covered services.
- If you require specialty care (except pediatric and orthodontic), your network general dentist will refer you to a network specialist.
- Your plan has no dollar maximums and no claim forms to file.
- Coverage for most preventive services is provided at \$0 or low charge.
- At the time of service, your dentist will collect the applicable co-payment for covered expenses as described on your Patient Charge Schedule.
- Alternate benefit provisions apply.

More Reasons to Smile

- You don't need a referral for children under seven to visit a network pediatric dentist – simply select a network pediatric dentist as a primary care dentist.
- You don't need a referral to receive care from a network Orthodontist.**
- Members with Cigna dental coverage may be eligible for reimbursement of copayments for certain services to treat gum disease. The **Cigna**

Dental Oral Health Integration Program® offers enhanced dental benefits for eligible members with certain medical conditions, including diabetes, cardiovascular disease or pregnancy. Visit myCigna.com to learn more about your plan, or call the number on your ID card or 1-800-CIGNA24 (1-800-244-6224).

***DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.*

***Orthodontic coverage does not apply to Retiree Plans.*

Cigna Dental refers to the following operating subsidiaries of Cigna Corporation: Connecticut General Life Insurance Company, and Cigna Dental Health, Inc., and its operating subsidiaries and affiliates. The Cigna Dental Care plan is provided by Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of Pennsylvania, Inc. In other states, the Cigna Dental Care plan is underwritten by Connecticut General Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.



HORIZON DENTAL

The Horizon Dental Choice (HDC) plan from Horizon Blue Cross Blue Shield of New Jersey is offered to eligible employees and retirees.

Employees are covered for 100 percent of all eligible preventive and most basic dental services with no copayments, maximums or deductible when services are provided by an HDC Primary Care Dentist. If you need major or specialty dental services, you will have an affordable copayment when services are provided by an HDC Primary Care Dentist.

Retirees are covered for 100 percent of all eligible preventive services and, depending on length of time continuously enrolled, will have more comprehensive coverage.

Refer to the Member Guidebooks for Employees or Retirees for a detailed list of covered services and specific copayments, when applicable, as well as eligibility rules and enrollment policies.

With HDC, care must be coordinated through the in-network dentist who you select as your primary care dentist (PCD). Visit HorizonBlue.com/doctorfinder to find the names, addresses and detailed door-to-door directions of dentists in the HDC network. Your PCD's name will be listed on your member ID card. Each member can choose his or her own PCD and can change this selection to another in-network dentist at any time.

If you need treatment outside the scope of your PCD's practice, your PCD will refer you to a Horizon Dental PPO specialist. There is no out-of-network benefit.

Questions? Call us at **1-800-4DENTAL (1-800-433-6825)**. Representatives are available to help you Monday through Friday, between 8 a.m. and 8 p.m., Eastern Standard Time (EST).

See plan documents for a complete description, including limitations, exclusions and waiting periods.

Services and products provided by Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare Dental, Inc., are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross and Blue Shield of New Jersey.



International Healthcare Services, Inc.

International Healthcare Services (IHS), Inc. is a DPO certified by the State of New Jersey. IHS has participated with the New Jersey Public Employee Dental Plans for more than 25 years. Healthplex, Inc. is the dental plan administrator.

Healthplex is certified as a Credentials Verification Organization (CVO) by the National Committee for Quality Assurance (NCQA)* and credentials its providers according to NCQA standards. You can be sure that all participating dentists have been thoroughly screened regarding education, licensure, malpractice history and other key elements. In addition, we perform site visits during which we review office cleanliness, sterilization methods, record keeping and staffing. With IHS/Healthplex, you can be assured that the office you select is qualified and meets or exceeds established standards of care!

The DPO Plan

Many services are covered in full without any patient copayment: exams, x-rays, cleanings, and fluoride treatments are provided at no cost. Other more complex services have patient copayments that are a fraction of usual fees.

Examples		
Procedure	Active Members	Retired Members
Porcelain/Noble Metal Crown	\$225	\$340
Root Canal on front tooth	\$225	\$340
Periodontal Osseous Surgery, per quadrant	\$175	\$265
Full Denture	\$250	\$340
Extraction of Erupted Tooth	\$20	\$35

This plan has no deductibles or annual maximums. For a complete copayment schedule, exclusions, limitations and waiting periods, please refer to the Employee Dental Plans Member Guidebook.

If you would like to find a participating dentist, go to www.healthplex.com and select "Our Dentists" Under "Member," you can log in to your account or enter the group number located on your ID card. Or, you may call us for plan or dentist information at 1-800-468-0600.

Our website allows you to request ID cards, verify eligibility, review claim status, and more. To register, go to www.healthplex.com

Thank you for considering IHS/Healthplex for your dental needs!

**NCQA is an independent, non-profit organization dedicated to assessing and reporting on the quality of America's health plans*



After you select dental coverage, you can also visit the MyBenefits website at www.MetLife.com/mybenefits to find more information regarding dental benefits offered to you by the State of New Jersey.

DENTAL INSURANCE

Something to smile about.

Routine dental exams do more than protect your teeth. They can help protect your health by catching serious problems, such as diabetes and heart disease. In fact, more than 90 percent of all diseases produce oral signs and symptoms.¹ Without dental coverage, out-of-pocket costs for cleanings, exams, and dental procedures can really add up.

Learn more about how to protect your health and your wallet with the MetLife Dental HMO (DHMO)/Managed Care.

Don't worry, you're covered

You get a broad network of carefully screened general dentists and specialists who provide quality dental care at a much lower cost. You enjoy significantly lower out-of-pocket costs for more than 400 covered procedures including:

- Up to 2 cleanings per year
- Preventive care (exams, sealants, x-rays)
- General anesthesia, Intravenous sedation and nitrous oxide
- Root canals and extractions
- Porcelain and titanium crowns
- White fillings on rear teeth
- Coverage for specialty care

There are no waiting periods, claims forms, deductibles, or annual maximums. Also, you and eligible family members qualify for competitive group rates and automated payroll deduction makes payments convenient.

Selecting a dentist

In exchange for lower costs, this plan has some simple requirements:

- Your primary dentist coordinates specialty care for you. You must pre-select a dentist who participates in the network.
- Each family member may select a different dentist and may change his or her selection up to once a month.
- To see if your dentist is a provider in the MetLife DHMO/Managed Care Network, go to www.metlife.com/dental and select the applicable SHBP/SEHBP Plan.

For more information

To learn more about how to enroll in Dental insurance, contact a benefits administrator at the NJDPB Office of Client Services or visit the NJDPB website.

Once enrolled, you can call 866-880-2984, Monday-Friday, 8 a.m. - 11 p.m. EST to learn more about your dental insurance.

¹Academy of General Dentistry. *The importance of Oral Health to Overall Health.* <http://www.knowyourteeth.com/infobites/abc/article/?abcT&ii<F320&ai<F1289>

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

DHMO is used to refer to product designs that may differ by state of residence of the enrollee, including but not limited to: "Specialized Health Care Service Plans" in California; "Prepaid Limited Health Service Organizations" as described in Chapter 636 of the Florida statutes in Florida; "Single Service Health Maintenance Organizations" in Texas; and "Dental Plan Organizations" as described in the Dental Plan Organization Act in New Jersey.

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Whether an employee or a retiree, you'll love the flexibility of the Dental Expense Plan!

ACTIVE AND RETIREE DENTAL EXPENSE PLANS

Aetna Dental is the claims administrator of the Active and Retiree Dental Expense Plans. Members enrolled in these plans receive an Aetna member identification card with a PPO network identifier.

Dental Expense Plan Network Access — When it comes to oral health, nothing may be more important to our members than having access to quality dentists. Members have access to our quality PPO networks nationwide.

Both the Active and Retiree plans offer national access to dentists and quality coverage with no referrals required.

Please note that the Dental Expense Plan has different in-network and out-of network benefits. This means that, by using Aetna's network of dental PPO providers, you have the opportunity to save on your costs when compared to using out-of-network providers.

Ah, Freedom! See any licensed dentist you choose!

- No referrals required.
- No need to choose a primary care dentist.
- Affordable coverage for cleanings, X-ray, restorative work and more.

It's your choice whenever you need dental care....

Choice 1: The best way to maximize your dollar! Simple, affordable coverage by visiting a participating PPO dentist from Aetna's national PPO network.

Participating dentists have agreed to offer certain services at a negotiated rate — so you generally pay less out-of-pocket for your care.

- Check DocFind® to see if your dentist is participating or to simply see who is participating.
- Your participating Aetna PPO dentist will submit claims for you.

Choice 2: Visit any dentist of your choice for maximum flexibility under your plan. However, you may potentially pay more out of pocket for your dental services.

- See any licensed dentist. You have the freedom to visit a licensed dentist who does not participate in the Aetna PPO network.
- Only participating dentists have agreed to discounted rates for Aetna members, so your out-of-pocket expenses will be higher when you go outside the network.
- You may have to file your own claims and you may be subject to balance billing (the difference between the amount covered by your plan and the amount charged by your dentist).

For a more complete overview of the plan including covered and not covered services please refer to your *Dental Plans Member Guidebook*.

Dental Health Information at Your Fingertips

Visit the *Simple Steps to Better Dental Health* website to find articles, illustrations, interactive tools, information on dental conditions, treatments, and more. To explore *Simple Steps to Better Dental Health* go to www.simplestepsdental.com

We offer fast, accurate customer service. Our dedicated dental service centers are staffed with dental experts who are determined to solve problems the first time, leading to fast and accurate problem resolution and claim processing.

Our technology makes it easy to get service and information when and how you want it.

- Email with 24 hour response time.
- 24-hour phone access

Our member website allows you to:

- Choose a plan that fits your needs
- Learn about the plan benefits
- Register for Aetna Navigator
- Search for a provider in Aetna's DocFind
- Contact Member Services with a question

Aetna Navigator™ — A powerful web-based tool designed to help you access and navigate a wide range of oral health information and programs. Navigator provides a single source for online benefits and dental-related information. As an enrolled Aetna member you can register for a secure, personalized view of your Aetna benefits 24 hours a day, 7 days a week where you

have Internet access. Navigator allows you to request member ID cards, verify eligibility, review plan coverage details, review claim status, claim detail information and more. To register, go to **www.AetnaStateNJ.com** and find Aetna Navigator under Quick Links

DocFind® — It's easy to choose a participating PPO dentist and search for participating specialty dentists from our extensive network via the Internet. You can select a dentist based on geographic location, dental specialty, and/or languages spoken. DocFind is updated virtually every day, giving you access to the most up-to-date list of participating dental providers. To use DocFind, simply go to **www.AetnaStateNJ.com**

Member Services is also available to assist you by calling the number on the back of your ID card.

Did You Know? The signs of a health problem may show up first in your mouth, and a dentist can spot these signs. As mouth infections may affect other parts of your body, this means that good oral health has never been more important.

Aetna Membership Brings You Even More

When you enroll in an Aetna dental plan, you also get the Aetna Extras. You pay nothing to join and you'll have access to savings that can help you and your family. Save by using eight different discount programs that range from fitness and weight management to hearing and vision. Visit Aetna Navigator or call the number on your Aetna ID card for more information on how to access the great value-added services below!

Show your Aetna ID card at participating locations to save on:

- Eye care products, including eyeglasses, contact lenses, non prescription sunglasses and accessories
- Eye exams at thousands of locations nationwide
- LASIK eye surgery
- Hearing products
- Membership in participating health clubs
- Certain home exercise equipment
- Chiropractic, acupuncture, vitamins, and more!

EMPLOYEE ASSISTANCE PROGRAMS

Employee Assistance Programs (EAP) are staffed by professional counselors who can help employees and their eligible dependents handle problems such as stress, alcoholism, drug abuse, mental health conditions, and family difficulties. An EAP will provide education, information, counseling, and individual referrals to assist with a wide range of personal or social problems. The EAP will also assist you in obtaining a referral to the proper health care provider, and help in day-to-day communications with your health plan.

An employee's contact with this service is private, privileged, and strictly confidential. No information will be shared with anyone at any time without your written consent.

The following EAP services are available to State Employees:

State Employee Advisory Service
(EAS) 24 hours a day. 1-866-EAS-9133

New Jersey
State Police EAP 1-800-FOR-NJSP

Rutgers University
Behavioral Health Care (973) 972-5429

Employees of local employers may have an EAP available to them. To find out about such services, you should check with your employer's human resources office.

TAX\$AVE FOR STATE EMPLOYEES

Tax\$ave is a benefit program, defined by Section 125 of the federal Internal Revenue Code (IRC), that allows eligible New Jersey State employees to use pre-tax dollars to pay for qualified medical, dental, and dependent care expenses and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the

health, dental, or dependent care deduction. Tax\$ave consists of three components:

- The **Premium Option Plan (POP)** allows eligible New Jersey State employees to make payments for basic health and dental plan premiums on a pre-tax basis, thereby increasing their take-home pay. Any increase in take-home pay will depend on the health and/or dental plan selected and the level of coverage ("Single," "Member and Spouse/Partner," "Parent and Child(ren)," or "Family").
- The **Unreimbursed Medical Spending Account Plan (UMSA)** allows eligible New Jersey State employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered (see limitations on civil unions and same-sex domestic partners, on page 31).
- **Note:** Federal law prohibits participation in both a flexible spending account (FSA) such as the UMSA and a health savings account (HSA). Therefore, if you are enrolled in a HDHP, you are not eligible to enroll in this plan.
- The **Dependent Care Spending Account Plan (DCSA)** allows an eligible New Jersey State employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

The UMSA and DCSA are administered for the NJDPB by WageWorks, Inc.

Tax\$ave Open Enrollment

State Employees may join Tax\$ave or make changes to a Tax\$ave account during the Tax\$ave Open Enrollment period. Enrollment in the POP is automatic unless enrollment is specifically declined each year.

The *Tax\$ave* Fact Sheet outlines the Tax\$ave Program and may be obtained from your benefits administrator or from the NJDPB website.

Note: The Tax\$ave program is not available to local employees; however, your employer must offer a similar program. Contact your employer to find out about pre-tax IRC Section 125 programs offered by your employer.

EFFECT OF POP PARTICIPATION ON SHBP RULES AND PROCEDURES

Your participation in the **POP** may affect your participation in the SHBP.

As a State employee, you are automatically enrolled in the POP and save on taxes for any health and/or dental premiums you pay through payroll deductions — unless you decline enrollment at the time you first become eligible for health and dental plan coverage or during the Tax\$ave Open Enrollment period (see "Declining POP" on page 31).

The Tax\$ave Program is strictly regulated by the Internal Revenue Service (IRS) because of the tax advantages provided under the POP. IRS rules require that for an employee covered by the POP, payroll deductions for health and/or dental plan benefits remain the same for the entire plan year. Therefore, no coverage level changes can be made to your health and/or dental plan enrollment that would result in a change in the amount of your deduction unless a "qualifying event" has occurred. If a qualifying event does occur (see page 31), you may make a change by submitting a completed application to your employer within 60 days of a qualifying event or during the annual Tax\$ave Open Enrollment period.

Qualifying Events

- A marriage (employee may enroll spouse and any other eligible dependents).
- Addition of an eligible dependent due to birth, adoption, or legal guardianship.
- A change in family status involving the loss of eligibility of a family member (separation, divorce, death, child turns age 26).
- The termination of a member's employment for any reason, including retirement.
- Taking an approved unpaid leave of absence.
- A change in an eligible dependent's employment status resulting in his/her loss of health and/or dental coverage.
- Such other events that may be determined to be appropriate and in accordance with applicable IRS regulations.

Declining POP

Since enrollment is automatic for employees with health or dental plan deductions, a newly-hired employee who does not want to participate in the POP may decline participation by completing a *Declination of Premium Option Plan* form that can be obtained from the employee's Human Resources Representative or Payroll Clerk.

Leave Without Pay (LWOP)

The election in effect at the beginning of the plan year will continue until a change is made during the Tax\$ave Open Enrollment period or upon the occurrence of a qualifying event. An employee who declined enrollment in the POP and is on leave during the Annual Open Enrollment Period may elect enrollment in the POP upon return to active employment.

Civil Unions, Domestic Partners, and Tax\$ave

The IRS does not recognize a New Jersey civil union partner or same-sex domestic partner as a dependent for tax purposes in the same manner that it recognizes a spouse or dependent children of an employee. Therefore, your employer may have to treat the civil union partner or same-sex domestic partner SHBP benefit as federally taxable.

As a result, a civil union partner or same-sex domestic partner must be able to qualify as a "tax dependent" of the employee for federal tax filing purposes — under IRC Section 152 — before an out-of-pocket medical expense incurred by the partner can be reimbursed under the **UMSA** and before any premiums that the employee pays for the partner's coverage can be made on a pre-tax basis under the **POP**. See IRS *Publication #503, Dependents*, for additional information on the requirements for establishing dependent status for federal tax purposes.

If the civil union partner or same-sex domestic partner is *not* a qualified tax dependent of the employee, the partner's SHBP coverage is considered federally taxable and the employee *cannot* be reimbursed under the UMSA for any out-of-pocket medical expense incurred by the partner, nor make pre-tax payments for the cost of the civil union or domestic partner's coverage under the POP (pre-tax dollars may still be used to pay for the employee's portion of the cost of his or her own and dependent children's coverage).

The civil union or same-sex domestic partner SHBP benefit is not subject to New Jersey State income tax. If you live outside of New Jersey, you should check with your State's tax agency to determine if the civil union or same-sex domestic partner SHBP benefit is subject to state taxes.

ENROLLING IN HEALTH BENEFITS

ACTIVE EMPLOYEE ENROLLMENT

You are not covered until you enroll in the SHBP or SEHBP. You must fill out a *Health Benefits Enrollment and/or Change Form* and provide all the information requested along with any required supporting documentation. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so (see "Change of Coverage" for exceptions).

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees, retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 47 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Open Enrollment

An annual Open Enrollment period is held for all eligible State employees and local participating employees. Specific dates for the Open Enrollment period are announced in advance. Coverage changes made during the Open Enrollment period will be effective the first biweekly payroll period of the new plan year for State employees paid through the State's Centralized Payroll Unit, and January 1 of the following year for all other State and local employees. Completed applications must be returned to your human resources represen-

tative or payroll officer by the deadline indicated in the Open Enrollment announcement materials.

The annual Open Enrollment period is your opportunity to make changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- enroll in any of the plans offered for which you are eligible, if you have not previously enrolled;
- change to another eligible health plan;
- enroll in, or change dental plans (if eligible and enrolled in your previous dental plan for a minimum of 12 months);
- add eligible dependents you have not previously enrolled (including over age children eligible under Chapter 375, see page 6); and
- delete dependents (this can also be done at any time during the year).

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose "Family" coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose "Single" coverage and the spouse may choose "Parent and Child(ren)" coverage.

Waiver of Coverage

An employer other than the State participating in the SHBP or SEHBP may allow an employee who is covered as a dependent under a spouse's or partner's employer-provided health benefits coverage to waive SHBP or SEHBP health benefits coverage and be reimbursed up to 25 percent of the amount saved by the employer, or \$5,000, whichever is less. Coverage may be resumed if the spouse's or partner's dependent coverage is no longer in effect. The decision of an employer to allow its employees to waive coverage and the amount of consideration to be paid are not subject to collective bargaining.

Change of Coverage

To change your coverage, you should contact your benefits administrator or human resource representative. To change your coverage due to any of the circumstances listed below, **you must submit a completed *Health Benefits Enrollment and/or Change Form* and all required supporting documentation within 60 days of the event.** See page 47 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

You are eligible to change your level of coverage within the same plan under the following circumstances:

- You marry and want to enroll your spouse and newly-eligible children. A photocopy of the *Marriage Certificate*, and/or birth certificates for any children, and all required supporting documentation must accompany the application;
- You enter into a civil union or same-sex domestic partnership and want to enroll your eligible partner and newly-eligible children. A photocopy of the *New Jersey Civil Union Certificate*, *Certificate of Domestic Partnership*, and/or birth certificates for any children, and all required supporting doc-

umentation must accompany the application (may not apply to all employees, see page 5 for additional information about eligible same-sex domestic partners);

- You need to enroll a child. A photocopy of legal documentation (birth certificate, adoption or guardianship papers, etc.) must accompany the application (non-custodial parents, see page 48);
- You have a change in family status involving the loss of eligibility of a family member (divorce; dissolution of a civil union or same-sex domestic partnership; death);
- Your dependent's employment status changes resulting in a loss of health coverage. A photocopy of your dependent's *Certificate of Continued Coverage* and required supporting documentation must accompany the application; or
- You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from "Family" to "Parent and Child(ren)" coverage when you go on leave and increase it back to "Family" upon your return to work.

You are eligible to change your coverage to another plan under the following circumstance:

- You return from a leave of absence. If you elected not to continue benefits while on leave of absence, or you missed the open enrollment period, upon your return from leave you may elect to enroll in any plan for which you are eligible or at any coverage level as appropriate.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your health benefits coverage begins, provided you submit a completed *Health Benefits Enrollment and/or Change Form*

and all required supporting documentation. Your enrolled dependent's coverage is effective the same date as yours, provided you have paid any required contribution.

Coverage for State biweekly employees begins on the first day of your fifth payroll period. The exact date of your coverage will be determined by the State's Centralized Payroll date schedule. Contact your benefits administrator or human resources representative if you need to know the exact date of coverage.

For all other employees, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following exceptions apply to this effective date of coverage:

- If you have at least two months of service on the date your employer joins the SHBP or SEHBP, your coverage starts on the date your employer enters the program;
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1; and
- If you were enrolled in the SHBP or SEHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately so you have no break in coverage (see "Transfer of Employment").

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, civil union, birth, adoption, etc.) provided that the application and all required supporting documentation is filed within 60 days of the event.

Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau, except for the fol-

lowing:

- Dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage; or
- Children covered under the provisions of Chapter 375 are terminated from coverage on the first of the month following the event that no longer makes them eligible.

Transfer of Employment

If you transfer from one participating employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that you:

- are still enrolled by the SHBP or SEHBP (COBRA, State part-time, and part-time faculty coverage excluded) when you begin in your new position; or
- transfer from one participating employer to another; **and**
- file a new *Health Benefits Enrollment and/or Change Form* listing the former employer in the appropriate section of the application.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness;
- Approved leave of absence other than illness;
- Family Leave Act (federal and State);
- Furlough;
- Workers' Compensation; and
- Suspension (COBRA continuation only).

While you are on leave of absence, you can choose

to reduce your level of coverage for the duration of your leave and increase it again when you return from leave. For example, you can reduce "Family" coverage to either "Parent and Child(ren)" or "Single" coverage. Please note that it is necessary to complete a *Health Benefits Program Application* to decrease your coverage and also to reinstate it once you return to work. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence.

Family and Medical Leave Act

Enrolled State and local employees are entitled to have their health benefits coverage continued at the expense of their employer while they are on family leave. You must remit to your employer, in advance, that portion of the premiums you normally pay.

Furlough

If you take an approved furlough, your health benefits coverage will continue for up to 30 days of furlough. However, you must remit to your employer, in advance, any contribution or portion of the premiums that you normally pay.

Extensions beyond the normal 30 furlough days are an exception and you will have to pay, in advance, for the full cost of health benefits coverage for your extended furlough, or drop your coverage for the entire benefit period in which you take an extended furlough day.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, the portion of the premiums that you would normally pay.

Suspension

If you are suspended from work, you are not eligible for employer-paid coverage. You may be eligible for coverage under COBRA (see page 40) under certain circumstances. Contact your benefits administrator or human resources representative for more information concerning coverage while on suspension.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a *Health Benefits Enrollment and/or Change Form* (and include any required documentation for new dependents). You must complete this application within 60 days after you return to work. Coverage becomes effective on the date you return to work if you are a State monthly or local employee, or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your return to work and the completion of a *Health Benefits Enrollment and/or Change Form*.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment-types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you

purchased COBRA coverage while on leave, you must file a new *Health Benefits Enrollment and/or Change Form* within 60 days of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

End of Coverage

Coverage for you and your dependents will end if:

- you voluntarily terminate coverage;
- your employment terminates;
- your hours are reduced so you no longer qualify for coverage;
- you do not make required premium payments;
- your plan discontinues services in your area and you do not submit an application to the Health Benefits Bureau to change to another plan;
- your employer ceases to participate in the SHBP or SEHBP; or
- the SHBP or SEHBP are discontinued.

Coverage for your dependents (including over age children eligible under Chapter 375, see page 6) will end if:

- your coverage ceases for any of the reasons listed above;
- you die (dependent coverage terminates the first day of the biweekly coverage period following the date of death of State employees paid through the State's Centralized Payroll Unit, or the first of the month following the date of death for all other employees);
- your dependent is no longer eligible for coverage (divorce of a spouse; dissolution of a civil union or same-sex domestic partnership; child is over age 26 — age 31 if covered under Chapter 375 — except where the over age child qualifies for coverage due to disability — see page 6); or

- your dependent becomes enrolled on his/her own as an SHBP or SEHBP subscriber.

Medicare Parts A and B

In general, it is not necessary for a Medicare-eligible employee, spouse/partner, or dependent child(ren) to be covered by Medicare while the employee remains actively working. **However, if you or your dependents become eligible for Medicare due to End State Renal Disease (ESRD)**, and the 30-month coordination of benefits period has ended, you and/or your dependents **must enroll** in Medicare Parts A and B even though you are actively working. For more information see the "Medicare Coverage" section on page 36.

Medicare Part D

Most employees and/or Medicare-eligible dependents who do enroll in Medicare need not enroll in Medicare Part D Prescription drug coverage. Some members who qualify for low-income subsidy programs may find it beneficial to enroll in Medicare Part D.

RETIREE ENROLLMENT

You are not covered as a retiree until you enroll in the SHBP or SEHBP. Many members enrolled as active members are automatically enrolled as retirees. If not, you must fill out a *Retiree Health Benefit Enrollment and/or Change Form* and provide all the information requested within 60 days of being offered enrollment.

Note: Employees eligible to enroll for coverage in SHBP or SEHBP at the time of retirement cannot enroll for health benefit coverage under COBRA.

Supporting Documentation Required for Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees, retirees, and their dependents, are receiving health care coverage under the program. Re-

tirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application. See page 47 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent.

Eligible children may only be covered by one participating subscriber.

For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose "Family" coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose "Single" coverage and the spouse may choose "Parent and Child(ren)" coverage.

Waiver of Coverage

As an eligible retiree:

- You may file a *Cancel/Decline/Waive Retired Coverage Form* to waive coverage with the Retired Group and retain your right to enroll at a later date if you are covered as an employee or as a dependent of your spouse, civil union partner, or same-sex domestic partner in another public or private employer group health plan. You will retain your right to enroll in the Retired Group when your coverage with the other employer terminates, pro-

vided that you submit a completed *Retiree Health Benefit Enrollment and/or Change Form*, and provide proof that the previous coverage was in effect.

- If you are otherwise-eligible for enrollment under the provisions of P.L. 1997, c. 330 (Chapter 330), you must waive coverage if you have other coverage through active employment after retirement. You will retain your right to enroll in the Retired Group when your coverage terminates with the other employer, provided that you submit a completed *Retiree Health Benefit Enrollment and/or Change Form* within 60 days of the loss of coverage and request enrollment materials.

Medicare Part A and Part B

Important: A Retired Group member and/or dependent spouse, civil union partner, same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in Retired Group coverage.

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or a covered dependent becomes eligible for that coverage. Acceptable documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment or a letter from Medicare indicating the effective dates of both Part A and Part B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions & Benefits, P.O. Box 299, Trenton, NJ 08625-0299 or fax it to (609) 341-3407. If you do not submit evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

Important: If a provider is not registered with or opts out of Medicare, no benefits are payable under the SHBP or SEHBP for the provider's services, the charges will not be considered under the medical plan, and the member will be responsible for the charges.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in Medicare Part D and the OptumRx Medicare Prescription Drug Plan (PDP).

Important: If you decide not to be enrolled in the OptumRx PDP, you will lose your prescription drug benefits provided by the SHBP/SEHBP. However, your medical benefits will continue. In order to waive the OptumRx Medicare PDP, you must enroll in another Medicare Part D Plan. To request that you not be enrolled, you must submit proof of enrollment in another Medicare Part D plan.

If you have waived your prescription drug coverage for another Medicare Part D plan, and you wish to re-enroll in the OptumRX Medicare PDP, you must send proof of your termination from the other Medicare Part D plan. Acceptable proof is a letter confirming the date upon which you are disenrolled from the other Medicare Part D plan. We must receive this proof within 60 days of the termination from the other Medicare Part D plan.

Medicare Eligibility

In most cases, a Retired Group member and/or dependent should enroll in Medicare Part A and Part B coverage as soon as they become eligible. Otherwise, an individual can only enroll during Medicare's annual "General Enrollment Period" (January 1 through March 31) and late enrollment penalties may apply (visit www.medicare.gov or contact Medicare at 1-800-633-4227 for more information).

A member may be eligible for Medicare for the following reasons:

- **Medicare Eligibility by Reason of Age**

A member (the retiree or covered spouse/partner) is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The Retired Group health plan is the secondary plan (except for Medicare Advantage Plans);

- **Medicare Eligibility by Reason of Disability**

A member (the retiree or covered spouse/partner or dependent) who is under age 65 is considered to be eligible for Medicare if they have been receiving Social Security Disability benefits for 24 months.

The Retired Group health plan is the secondary plan (except for Medicare Advantage Plans);

- **Medicare Eligibility by Reasons of End Stage Renal Disease.**

A member (the retiree or covered spouse/partner or dependent) who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of his/her own or through a family member (including a spouse); and
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules listed above, known as the Medicare Secondary Payer (MSP) rules, are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

Currently, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

— **Three-month waiting period** (see "Note" on page 37)

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Part A and Part B benefits. During the initial three-month period, the group health plan is primary.

— **Coordination of benefits period** (see "Note" on page 37)

During the coordination of benefits period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan, and Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.

— **When Medicare is primary** (see “Note”)

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary. If you are eligible for Medicare by reason of ESRD and Medicare is primary, you must enroll in Medicare A and B and submit proof of enrollment to the SHBP/SEHBP. If you do not enroll in Medicare A and B before the end of the coordination of benefits period, your SHBP/SEHBP coverage will be terminated. It is your responsibility to ensure that you file your application for Medicare so that the Medicare effective date is on or before the date that the coordination of benefits period ends.

Note: If you are a Medicare Advantage member, some of these scenarios do not apply. Once your three-month waiting period ends and you become eligible for Medicare, you will be enrolled in the Medicare Advantage Plan, which pays primary to Medicare.

Dual Medicare Eligibility

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary for 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

**How to File a Claim If You
Are Eligible for Medicare¹**

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under “Other Health Insurance.”
- The physician or provider will then submit the Medicare Request for Payment to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: “This information has been forwarded to (name of your plan) for their consideration in processing supplementary coverage benefits.”
- If the statement shown above does not appear on the *Explanation of Benefits*, you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form of your plan.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment Form* should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.

- When you receive the *Explanation of Benefits*, indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

**ADDITIONAL RETIREE
ENROLLMENT INFORMATION**

Limitations on Enrolling Dependents

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, civil union, same-sex domestic partnership, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility. A *Retiree Health Benefit Enrollment and/or Change Form* plus required supporting documentation (marriage certificate, civil union/domestic partnership certificate, birth certificate, proof of dependency, etc.) must be submitted within the 60 days. See page 47 for more information about the documentation a member must provide when enrolling a new dependent for coverage.

If the application to add a spouse, civil union partner, same-sex domestic partner, or dependent is not received within 60 days of the status change (or required documentation is not provided), there will be a minimum two-month waiting period from the date the enrollment application is received until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time. Decreases in coverage will be processed on a timely basis. **It is your responsibility to notify the Health Benefits Bureau of the**

¹ Does not apply to Medicare Advantage Plans.

NJDPB of any change in family status. If family members are not properly enrolled, claims will not be paid.

Change of Coverage

To change Retired Group coverage you must complete a *Retiree Health Benefit Enrollment and/or Change Form* which is available on our website.

There is no specific Open Enrollment period for Retired Group members. A retiree can switch medical plans once in any 12-month period or when rates change.

Retirees are also eligible and should change coverage under the following circumstances:

- You marry and want to enroll your spouse. Photocopies of the marriage certificate and additional supporting documentation are required for enrollment;
- You enter into a civil union or same-sex domestic partnership and want to enroll your partner. Photocopies of the *Civil Union Certificate*, or *Certificate of Domestic Partnership* and additional supporting documentation are required for enrollment (may not apply to all retirees, see page 5 for additional information about same-sex domestic partners);
- You need to enroll a new child. Photocopies of the child's birth certificate and any additional supporting documentation are required;
- You have a change in family status involving the loss of eligibility of a family member (separation; divorce; dissolution of a civil union or same-sex domestic partnership; death). Dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage; or
- Your spouse/partner's employment status changes resulting in a significant change in health coverage.

Important: Retirees should immediately notify the Health Benefits Bureau of changes in family status. Deleting coverage for dependents may affect premium rates and, although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau*. Failure to submit a *Retiree Health Benefit Enrollment and/or Change Form* to remove a deceased or ineligible spouse/partner for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

Effective Dates

You are responsible for notifying the Health Benefits Bureau of a coverage change due to death, divorce, or dissolution of a civil union or domestic partnership. The effective date is the first day of the month following the date of death, divorce, or dissolution. Any claims incurred or services provided after this date are ineligible for payment.

The effective date of any other change or termination of coverage is based on the billing cycle in which the change or termination is received. For example, in most cases, if an application for a change is received before January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

- you formally request termination in writing, or by completing a *Retiree Health Benefit Enrollment and/or Change Form*;
- your retirement is canceled;
- your pension allowance is suspended;

- you do not pay your required premiums;
- you or your spouse/partner do not provide proof of enrollment in Medicare Part A and Part B when eligible for Medicare coverage or your Medicare coverage ends;
- your former employer withdraws from the SHBP or SEHBP (this may not apply to certain retirees of education, police, and fire employers);
- you die (dependent coverage terminates the 1st of the month following the date of death); or
- the SHBP or SEHBP is discontinued.

Survivor Coverage

If you, the retired member, predecease your covered spouse/partner and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage. Surviving dependents are generally notified of their rights to continued coverage at the time the NJDPB is notified of the death of the retiree; however, they may contact the NJDPB Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the NJDPB as soon as possible after your death because their dependent coverage terminates the first of the month following the date of your death.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. In addition, certain members who lose their Retired Group coverage are allowed to continue coverage under COBRA. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage"), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription, dental, and vision), and you may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage; however, you cannot add dependents who were not covered while an employee except during the annual Open Enrollment period (see below) or unless a qualifying event (marriage, civil union, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

Open Enrollment — COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP or SEHBP medical coverage for which you are eligible and, if offered by your employer, State prescription drug and/or employee dental plan coverage during the Open Enrollment period, regardless of whether you elected to enroll for the coverage

when you first enrolled under COBRA. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If plan changes occur to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct);
- Death of the member;
- Reduction in work hours;
- Leave of absence;
- Divorce, legal separation, dissolution of a civil union or same-sex domestic partnership (makes spouse/partner and/or stepchildren ineligible for further dependent coverage);
- Loss of a dependent child's eligibility through the attainment of age 26; or
- The employee elects Medicare as primary coverage (federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage).

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Continuation of group coverage under COBRA is not permitted for an over age child who loses coverage under Chapter 375 (see page 6).

Cost of COBRA Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of COBRA Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of termination of employment, a reduction in hours, or a leave of absence.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration-approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your death, divorce, dissolution of a civil union or same-sex domestic partnership, or a child attaining age 26, or because you elected Medicare as your primary coverage.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities under COBRA

The COBRA law requires employers to:

- notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- notify you, your spouse/partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA-qualifying event that causes a loss of coverage;
- send the *COBRA Notification Letter* and a *COBRA Application* within 14 days of receiving notice that a COBRA-qualifying event has occurred;
- notify the NJDPB within 30 days of the loss of an employee's coverage; and
- maintain records documenting their compliance with the COBRA law.

Employee Responsibilities under COBRA

The law requires that you and your dependents:

- notify your employer (if you are retired, you must notify the Health Benefits Bureau of the NJDPB) that a divorce, legal separation, dissolution of a civil union or same-sex domestic partnership, or death has occurred. Notification must be given within 60 days of the date the event occurred (dependent children are automatically terminated as of the end of the year they attain age 26 and do not require the completion of an application to decrease coverage);
- file a *COBRA Application* with the NJDPB within 60 days of the loss of coverage or the date of the *COBRA Notice* provided by your employer, whichever is later;

- pay the required monthly premiums in a timely manner; and
- pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP or SEHBP will end when any of the following situations occur:

- your eligibility period expires;
- you fail to pay your premiums in a timely manner;
- after the COBRA event, you become covered under another group insurance program;
- you voluntarily cancel your coverage;
- your employer drops out of the SHBP or SEHBP; or
- you become eligible for Medicare after you elect COBRA coverage (this affects health insurance only; not dental, prescription, or vision coverage).

SPECIAL PLAN PROVISIONS

Women's Health and Cancer Rights Act

The SHBP and SEHBP both adhere to the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans which cover mastectomies must cover breast reconstruction surgery to produce a symmetrical appearance, prostheses, and treatment of any physical complications.

Automobile-Related Injuries

The Program will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your medical plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your medical plan, then the SHBP or SEHBP will automatically be primary to your PIP policy. If you elect your medical plan as primary, this election may affect each of your family members differently.

When the SHBP or SEHBP is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the medical plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your PCP, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

Please note: If you are covered by the Retired Group and Medicare is primary for you and/or your spouse/partner, you do not have the option to select the SHBP or SEHBP as primary to your PIP policy.

If your SHBP or SEHBP plan is secondary to the PIP policy, the actual benefits payable will be the lesser of:

- the remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to medical appropriateness and any other provisions of your SHBP or SEHBP plan, after application of any deductibles and coinsurance; or
- the actual benefits that would have been payable had your SHBP or SEHBP plan been primary to your PIP policy.

If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your plan's guidebook and your PIP policy to assist you in making this decision.

Work-Related Injury or Disease

Work-related injuries or disease are not covered under the SHBP or SEHBP. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.
- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.
- Work-related tests, examinations, or immunizations of any kind required by your work.

Please note: If you collect benefits for the same injury or disease from both Workers' Compensation and the SHBP or SEHBP, you may be subject to prosecution for insurance fraud.

Mental Health Parity Act Requirements

The SHBP and SEHBP currently meet the federal requirement that all mental health illnesses be covered the same as any other illness, subject to medical necessity.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The Program makes every effort to safeguard the health information of its members and complies with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to a members' physical or mental health. See page 49 for the *Notice of Privacy Practices*.

NOTICE OF PROVIDER TERMINATION

Any person enrolled in an HMO must be provided with 90-days notice if that person's PCP will be terminated from the provider network. If 90-day notice cannot be provided, the HMO must notify the member as soon as possible. The covered person may then choose another PCP or may change coverage to another participating medical plan.

MEDICAL PLAN EXTENSION OF BENEFITS

If you are totally disabled with a condition or illness at the time of your termination from the SHBP or SEHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this specific condition or illness. To obtain more information about total disability and the extension of benefits, please contact your medical plan's claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which the person ceases to be a covered person. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

AUDIT OF DEPENDENT COVERAGE

Periodically, the NJDPB performs an audit using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of **all** coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

HEALTH CARE FRAUD

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP or SEHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

APPENDIX**CLAIM APPEAL PROCEDURES****MEDICAL APPEALS****Medical, Dental, and Prescription Drug Plans**

Appeals for SHBP/SEHBP members that question an adverse determination involving medical judgment are considered Medical Appeals.

Examples of Medical Appeals include the denial of a service(s) for:

- Cosmetic reasons;
- Medical necessity;
- Experimental/investigational; or
- Not meeting policy criteria.

Medical appeals have a two-level internal appeal process followed by an external appeal. The first two levels of appeal are conducted through your medical, dental, or prescription drug plan. A first-level appeal must be submitted within one year (180 days for HMOs) following your receipt of the plan's initial adverse benefit determination. Consult the appropriate member guidebook for specific instructions on filing these types of appeals.

Once the two levels of appeal are exhausted with the medical, dental, or prescription drug plans, you will have the option of filing a third-level appeal.

Medical Appeals and Administrative Prescription Plan Appeals, except for dental appeals, may be requested through your medical or prescription drug plan. Third-level dental appeals will be heard by the SHBC/SEHBC. Appeal requests for an Independent Review Organization (IRO) review must be submitted within four months from your receipt of the medical or prescription plan's final determination. The IRO will

provide a final review decision within 45 days after the IRO receives the complete appeal file. The IRO decision will be binding upon the medical or prescription plan.

ADMINISTRATIVE APPEALS**Medical and Dental Plans**

Appeals for SHBP/SEHBP members that question an adverse determination involving benefit limits, exclusions, or contractual issues are considered Administrative Appeals. Administrative Appeals must be submitted within one year following your receipt of the initial adverse benefit determination. Administrative Appeals might also question enrollment, eligibility, or plan benefit decisions such as whether a particular service is covered or paid appropriately.

Examples of Administrative Appeals are:

- Visits beyond the 30-visit Chiropractic limit;
- Benefits beyond the Reasonable & Customary Allowance;
- Routine vision services rendered out-of-network;
- Benefits for a wig that exceed the \$500/24-month limit;
- Hearing aid for a 60-year-old member; or
- Dispensing limits of a prescription drug.

The member or member's legal representative must appeal in writing to the SHBC/SEHBC. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf.

Request for SHBC/SEHBC consideration must contain the reason, in detail, for the disagreement along with copies of all relevant correspondence and should be directed to:

**Appeals Coordinator
State Health Benefits Commission or
School Employees' Health Benefits Commission
P.O. Box 299
Trenton, NJ 08625-0299**

Notification of all SHBC/SEHBC decisions will be made in writing to the member. If the SHBC/SEHBC denies the member's appeal, the member will be informed of further steps he or she may take in the denial letter from the SHBC/SEHBC. Any member who disagrees with the SHBC/SEHBC's decision may request in writing to the SHBC/SEHBC, within 45 days, that the case be forwarded to the Office of Administrative Law (OAL). The SHBC/SEHBC will then determine if a factual hearing is necessary. If so, the case will be forwarded to the OAL. An Administrative Law Judge will hear the case and make a recommendation to the SHBC/SEHBC, which the SHBC/SEHBC may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey Appellate Division.

If your case is forwarded to the OAL, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

HMO PLAN STANDARDS

Minimum coverage requirements and operating standards are established for all participating HMOs to safeguard members and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of benefit coverage for which mandatory expectations or requirements are imposed.

Standards Include:

- All physician referrals will be valid for a minimum of 90 days from the date of authorization;
- Certain treatments requiring numerous visits (e.g., chemotherapy) shall not require repeated referrals;
- Member packets must include a *Schedule of Benefits* which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions;
- The HMO will notify the State and members prior to any proposed changes in the provider network, including facilities, that alter member access to providers or services;
- There shall be no pre-existing condition restrictions;
- Network within network referral restrictions will not be permitted;
- Right to change PCPs must be permitted on at least a monthly basis;
- Scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member's PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year, and that a well-woman mammogram not require a PCP authorization;
- HMO members must be permitted to self-refer to network mental health and substance abuse practitioners; and
- Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA-continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:
 - the date the total disability ends;
 - the end of the calendar year after the one in which the person ceases to be a covered person;
 - the date the person has received the maximum benefits under the HMO plan for the disabling condition; or
 - the person becomes covered under any replacement plan established by the employer.

Emergency

The following definition for emergency care will be adhered to by all plans:

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

The copayment for emergency room services will be waived if admitted.

With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the HMO. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the HMO.

Minimum Coverage Requirements

Benefit standards include:

- Routine office visit copayments
- All plans will cover chiropractor visits up to a maximum of 20 visits per calendar year
- Hair prosthesis furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals will be covered (\$500 maximum)
- Routine inoculations for adults (not related to travel or occupation) will be covered
- The cost of care to organ transplant donors will be covered (coordination of benefits will apply)
- Admissions at skilled nursing homes will be covered up to 120 days per calendar year
- Hospice services will be covered in full

- Home health care will be covered up to a maximum of 120 visits per calendar year
- Provided all medical eligibility criteria are met, outpatient therapy will be covered up to 60 visits per condition per calendar year
- Repair and replacement of prosthesis will be covered
- Surgical leggings, ostomy supplies, and foot orthotics will be covered if medically necessary
- There will be no reimbursement for vision hardware

Mental Health and Alcohol/Substance Abuse

- All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM)
- Mental health conditions are treated like any other illness

NEW JERSEY HEALTH CARE PERFORMANCE REPORTS

New Jersey HMO Performance Report: Compare Your Choices

You can compare quality ratings of various HMOs with the New Jersey Department of Banking and Insurance's *New Jersey HMO Performance Report: Compare Your Choices*.

To obtain a copy of the latest *New Jersey HMO Performance Report: Compare Your Choices*, contact the New Jersey Department of Banking and Insurance, Division of Insurance, P.O. Box 325, Trenton, NJ 08625-0325, or call 1-800-446-7467. The report is also available online at: www.state.nj.us/dobi

New Jersey Hospital Performance Report

Available at the Department of Health website is the *New Jersey Hospital Performance Report* that contains information on the performance of all New Jersey acute care hospitals for two types of conditions — heart attack and pneumonia. Visit the Department of Health and Senior Services online at: www.nj.gov/health

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The SHBP and SEHBP are required to ensure that only employees, retirees, and their eligible dependents are receiving health care coverage under the programs. As a result, the NJDPB must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the appropriate health benefits application.

New Jersey residents can obtain records from the State Bureau of Vital Statistics and Registration website: www.nj.gov/health/vital To obtain copies of other documents listed on this chart, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these websites: www.vitalrec.com or www.studentclearinghouse.org

Dependent	Eligibility Definition	Required Documentation
Spouse	A person to whom you are legally married.	A photocopy of the <i>Marriage Certificate</i> and a photocopy of the front page of the employee's/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the spouse. If filing separately, submit a copy of both spouses' tax returns.
Civil Union Partner	A person of the same sex with whom you have entered into a civil union.	A photocopy of the <i>New Jersey Civil Union Certificate</i> or a valid certification from another jurisdiction that recognizes same-sex civil unions and a photocopy of the front page of the employee's/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
Domestic Partner	A person of the same sex with whom you have entered into a domestic partnership as defined under Chapter 246, the Domestic Partnership Act. The domestic partner of any State employee, State retiree, or any eligible employee or retiree of a SHBP/ SEHBP participating local public entity, who adopts a resolution to provide Chapter 246 health benefits, is eligible for coverage.	A photocopy of the <i>New Jersey Certificate of Domestic Partnership</i> dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners and a photocopy of the front page of the employee's/retiree's most recently filed NJ tax return* that includes the partner or a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

Dependent	Eligibility Definition	Required Documentation
Children	<p>A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents.</p> <p>This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.</p>	<p>Natural or Adopted Child – A photocopy of the child's birth certificate** showing the name of the employee/retiree as a parent.</p> <p>Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.</p> <p>Legal Guardian, Grandchild, or Foster Child – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.</p>
Dependent Children with Disabilities	<p>If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. See "Dependent Children with Disabilities" on page 6 for additional information. You will be contacted periodically to verify that the child remains eligible for continued coverage.</p>	<p>Documentation for the appropriate "Child" type (as noted above) and a photocopy of the front page of the employee's/retiree's most recently filed federal tax return* (<i>Form 1040</i>) that includes the child.</p> <p>If Social Security Disability has been awarded, or is currently pending, please include this information with the documentation that is submitted.</p> <p>Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.</p>
Continued Coverage for Over Age Children	<p>Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375. See "Over Age Children until Age 31" on page 6 for additional information.</p>	<p>Documentation for the appropriate "Child" type (as noted above), and a photocopy of the front page of the child's most recently filed federal tax return* (<i>Form 1040</i>), and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.</p>

*Note: On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

**Or a National Medical Support Notice (NMSN) if you are the non-custodial parent and are legally required to provide coverage for the child as a result of the NMSN.

NOTICE OF PRIVACY PRACTICES TO ENROLLEES**Protected Health Information (PHI)**

The SHBP and SEHBP (Programs) are required by the federal HIPAA and State laws to maintain the privacy of any information that is created or maintained by the Programs that relates to your past, present, or future physical or mental health. This PHI includes information communicated or maintained in any form. Examples of PHI are your name, address, Social Security number, birth date, telephone number, fax number, dates of health care service, diagnosis codes, and procedure codes. PHI is collected by the Programs through various sources, such as enrollment forms, employers, health care providers, federal and State agencies, or third-party vendors.

The Programs are required by law to abide by the terms of this Notice. The Programs reserve the right to change the terms of this Notice. If material changes are made to this Notice, a revised Notice will be sent.

Uses and Disclosures of PHI

The Programs are permitted to use and to disclose PHI in order for our members to obtain payment for health care services and to conduct the administrative activities needed to run the Programs without specific member authorization. Under limited circumstances, we may be able to provide PHI for the health care operations of providers and health plans. Specific examples of the ways in which PHI may be used and disclosed are to follow. This list is illustrative only and not every use and disclosure in a category is listed.

- The Programs may disclose PHI to a doctor or a hospital to assist them in providing a member with treatment.
- The Programs may use and disclose member PHI so that our Business Associates may pay claims

from doctors, hospitals, and other providers.

- The Programs receive PHI from employers, including the member's name, address, Social Security number, and birth date. This enrollment information is provided to our Business Associates so that they may provide coverage for health care benefits to eligible members.
- The Programs and/or our Business Associates may use and disclose PHI to investigate a complaint or process an appeal by a member.
- The Programs may provide PHI to a provider, a health care facility, or a health plan that is not our Business Associate that contacts us with questions regarding the member's health care coverage.
- The Programs may use PHI to bill the member for the appropriate premiums and reconcile billings we receive from our Business Associates.
- The Programs may use and disclose PHI for fraud and abuse detection.
- The Programs may allow use of PHI by our Business Associates to identify and contact our members for activities relating to improving health or reducing health care costs, such as information about disease management programs or about health-related benefits and services or about treatment alternatives that may be of interest to them.
- In the event that a member is involved in a lawsuit or other judicial proceeding, the Programs may use and disclose PHI in response to a court or administrative order as provided by law.
- The Programs may use or disclose PHI to help evaluate the performance of our health plans. Any such disclosure would include restrictions for any other use of the information other than for the intended purpose.

- The Programs may use PHI in order to conduct an analysis of our claims data. This information may be shared with internal departments such as auditing or it may be shared with our Business Associates, such as our actuaries.

Except as described above, unless a member specifically authorizes us to do so, the Programs will provide access to PHI only to the member, the member's authorized representative, and those organizations who need the information to aid the Programs in the conduct of its business (our Business Associates). An authorization form may be obtained on our website or by sending an email to: hipaform@treas.nj.gov

A member may revoke an authorization at any time.

Restricted Uses

- PHI that contains genetic information is prohibited from use or disclosure by the Programs for underwriting purposes.
- The use or disclosure of PHI that includes psychotherapy notes requires authorization from the member.

When using or disclosing PHI, the Programs will make every reasonable effort to limit the use or disclosure of that information to the minimum extent necessary to accomplish the intended purpose. The Programs maintain physical, technical and procedural safeguards that comply with federal law regarding PHI. In the event of a breach of unsecured PHI the member will be notified.

Member Rights

Members of the Programs have the following rights regarding their PHI:

Right to Inspect and Copy: With limited exceptions, members have the right to inspect and/or obtain a copy

of their PHI that the Programs maintain in a designated record set which consists of all documentation relating to member enrollment and the Programs' use of this PHI for claims resolution. The member must make a request in writing to obtain access to their PHI. The member may use the contact information found at the end of this Notice to obtain a form to request access.

Right to Amend: Members have the right to request that the Programs amend the PHI that we have created and that is maintained in our designated record set.

We cannot amend demographic information, treatment records, or any other information created by others. If members would like to amend any of their demographic information, please contact your personnel office. To amend treatment records, a member must contact the treating physician, facility, or other provider that created and/or maintains these records.

The Programs may deny the member's request if: 1) we did not create the information requested on the amendment; 2) the information is not part of the designated record set maintained by the Programs; 3) the member does not have access rights to the information; or 4) we believe the information is accurate and complete. If we deny the member's request, we will provide a written explanation for the denial and the member's rights regarding the denial.

Right to an Accounting of Disclosures: Members have the right to receive an accounting of the instances in which the Programs or our Business Associates have disclosed member PHI. The accounting will review disclosures made over the past six years. We will provide the member with the date on which we made a disclosure, the name of the person or entity to whom we disclosed the PHI, a description of the information we disclosed, the reason for the disclosure, and certain other information. Certain disclosures are exempted from this requirement (e.g., those made for treat-

ment, payment or health benefits operation purposes or made in accordance with an authorization) and will not appear on the accounting.

Right to Request Restrictions: The member has the right to request that the Programs place restrictions on the use or disclosure of their PHI for treatment, payment, or health care operations purposes. The Programs are not required to agree to any restrictions and in some cases will be prohibited from agreeing to them. However, if we do agree to a restriction, our agreement will always be in writing and signed by the Privacy Officer. The member request for restrictions must be in writing. A form can be obtained by using the contact information found at the end of this Notice.

Right to Restrict Disclosures: The member has the right to request that a provider restrict disclosure of PHI to the Programs or Business Associates if the PHI relates to services or a health care item for which the individual has paid the provider in full. If payment involves a FSA or HSA, the individual cannot restrict disclosure of information necessary to make the payment but may request that disclosure not be made to another program or health plan.

Right to Receive Notification of a Breach: The member has the right to receive notification in the event that the Programs or a Business Associate discover unauthorized access or release of PHI through a security breach.

Right to Request Confidential Communications: The member has the right to request that the Programs communicate with them in confidence about their PHI by using alternative means or an alternative location if the disclosure of all or part of that information to another person could endanger them. We will accommodate such a request if it is reasonable, if the request specifies the alternative means or locations, and if it continues to permit the Programs to collect premiums

and pay claims under the health plan.

To request changes to confidential communications, the member must make their request in writing, and must clearly state that the information could endanger them if it is not communicated in confidence as they requested.

Right to Receive a Paper Copy of the Notice: Members are entitled to receive a paper copy of this Notice. Please contact us using the information at the end of this Notice.

Questions and Concerns

If you have questions or concerns, please contact the Programs using the information listed at the end of this Notice (local county, municipal, and board of education employees should contact the HIPAA Privacy Officer for their employer).

If members think the Programs may have violated their privacy rights, or they disagree with a decision made about access to their PHI, in response to a request made to amend or restrict the use or disclosure of their information, or to have the Programs communicate with them in confidence by alternative means or at an alternative location, they must submit their concern in writing. To obtain a form for submitting a concern, use the contact information found at the end of this Notice.

Members also may submit a written concern to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Programs support member rights to protect the privacy of PHI. It is your right to file a concern with the Programs or with the U.S. Department of Health and Human Services.

Contact Office:

The Division of Pensions & Benefits
HIPAA Privacy Officer

Address:

Division of Pensions & Benefits
Bureau of Policy and Planning
P.O. Box 299
Trenton, NJ 08625-0299

Email: ***hipaaform@treas.nj.gov***

HEALTH BENEFITS CONTACT INFORMATION

Health and Dental plan telephone numbers and mailing addresses are located in the individual plan descriptions (beginning on page 13 for medical plans and page 22 for dental plans).

Addresses

Our mailing address is:

Division of Pensions & Benefits
P.O. Box 299
Trenton, NJ 08625-0299

Our website address is:

www.nj.gov/treasury/pensions

Our email address is:

pensions.nj@treas.nj.gov

Telephone Numbers

NJDPB:

Office of Client Services (609) 292-7524

TDD Phone

(Hearing Impaired). TRS 711 (609) 292-6683

State Employee Advisory

Service (EAS) 24 hours a day 1-866-EAS-9133
1-866-327-9133

New Jersey State Police Employee

Advisory Program (EAP) 1-800-FOR-NJSP

Rutgers University

Personnel Counseling Service

Employee Advisory Program (EAP). . . 1-800-327-3678

New Jersey Department of

Banking and Insurance

Individual Health Coverage

Program Board 1-800-838-0935

Consumer Assistance for

Health Insurance (609) 292-5316 (Press 2)

New Jersey Department of

Human Services

Pharmaceutical Assistance to the

Aged and Disabled (PAAD) 1-800-792-9745

New Jersey Department of Health

Division of Aging and

Community Services 1-800-792-8820

Insurance Counseling 1-800-792-8820

Independent Health Care

Appeals Program. (609) 633-0660

Centers for Medicare and

Medicaid Services

Medicare Part A and Part B. 1-800-MEDICARE

HEALTH BENEFITS PUBLICATIONS

The publications and fact sheets available from the NJDPB provide information on a variety of subjects. Fact sheets, guidebooks, applications, and other publications are available for viewing or downloading on our website.

General Publications

Summary Program Description — an overview of SHBP/SEHBP eligibility and plans

Plan Comparison Summary — out-of-pocket cost comparison charts for State employees, local government employees, local education employees, and all retirees.

Health Benefit Fact Sheets

Health Benefits Coverage – Enrolling as a Retiree
Health Benefit Programs and Medicare Parts A & B for Retirees
COBRA – The Continuation of Health Benefits
Termination of Employment through Resignation, Dismissal, or Layoff
Dental Plans – Active Employees
Health Benefits Retired Coverage under Chapter 330
Family Status Changes - Employees
Family Status Changes - Retirees
Health Benefits Coverage Continuation for Over Age Children with Disabilities
Health Benefits Coverage for Part-Time Employees
Health Benefits Coverage for State Intermittent Employees
Dental Plans – Retirees
Health Benefits Coverage of Children until Age 31 under Chapter 375
Civil Unions and Domestic Partnerships

Health Plan Member Guidebooks

Aetna HMO Member Guidebook
Aetna Liberty Member Guidebook
Aetna Freedom and Value HD Plans Member Guidebook
NJ DIRECT Member Guidebook
Horizon HMO Member Guidebook
Horizon OMNIA Member Guidebook
Prescription Drug Plans Member Guidebook
Employee Dental Plans Member Guidebook
Retiree Dental Plans Member Guidebook



State of New Jersey
Department of the Treasury
Division of Pensions & Benefits